FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08426

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08419

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b: 6 day.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Burtonsville
   d. STREET ADDRESS: 3934½ Greencastle
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Louis — Middle: H. — Last: Manning

4. **DATE OF DEATH**: Month: 6 — Day: 27 — Year: 1967

5. **SEX**: Male

6. **COLOR OR RACE**: Cauc.

7. **MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. **DATE OF BIRTH**: 2/12/88

9. **AGE** (In years last birthday): 79 yrs.
   IF UNDER 1 YEAR: Months: 4 — Days: 15
   IF UNDER 24 HRS.: Hours: — — Min.: —

10a. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Carpenter

10b. **KIND OF BUSINESS OR INDUSTRY**: Coleman Construction

11. **BIRTHPLACE** (State or foreign country): North Carolina

12. **CITIZEN OF WHAT COUNTRY?**: U.S.A.

13. **FATHER'S NAME**: Unknown

14. **MOTHER'S MAIDEN NAME**: Unknown

15. **WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No
    (If yes give war or dates of service)

16. **SOCIAL SECURITY NO.**

17. **INFORMANT** — Address: Holy Cross Hosp. chart records, Silver Spg., Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Cerebral edema — INTERVAL BETWEEN ONSET AND DEATH:
    DUE TO (b): Cerebral contusions — 6 days
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Vehicular accident

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary emphysema

19. **WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

20a. **EXTERNAL CAUSE WAS PRIMARY** ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. **DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.): Drove his car into rear of a truck on Route 495.

20c. **TIME OF INJURY** Month, Day, Year: Hour 4:30 a.m. p.m. — 6/21/1967

20d. **INJURY OCCURRED** While at work ☐ Not While at work ☒

20e. **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.): Beltway

20f. (City or town) Wheaton — (County) Silver Spring — (State) Montgomery Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

EXAMINER'S NAME (Type): John G. Ball, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. **DATE SIGNED**: 6/27/67.

Address (Street, city, town, or county): Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL: Burial

23b. DATE THEREOF: 6-30-67

23c. NAME OF CEMETERY OR CREMATORY: ------

23d. LOCATION (City or Town) (County) (State): Bethel, North Carolina

24. FUNERAL DIRECTOR: HYSONG FUNERAL HOME — ADDRESS: 1300-N 31-NW Washington, DC
PER: Thomas M. Hysong

25a. REC'D BY REGISTRAR — DATE: JUN 29 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08425 08418

1. PLACE OF DEATH
a. COUNTY: Montgomery
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Silver Spring
d. STREET ADDRESS: 10906 Jarboe Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle Joseph Lost Malone
4. DATE OF DEATH: Month June Doy 13 Year 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 15, 1895
9. AGE (In years lost birthday): 71 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Supervisor
10b. KIND OF BUSINESS OR INDUSTRY: D. C. Govt.
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick Malone
14. MOTHER'S MAIDEN NAME: Mary ~~Mahoney~~ Mahaney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give wor or dotes of service) WWI
16. SOCIAL SECURITY NO.: 578-36-3447
17. INFORMANT: Louise M. Malone
Address: 10906 Jarboe Avenue Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 1 Days
DUE TO (b): Carcinoma of lungs — 2 years
DUE TO (c): Diabetes Mellitus — 10 yrs
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost. 163 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Nephritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 6/13 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ___, 19__ to 6/13, 1967, that (I) (~~are~~) lost saw the deceased olive on 6/9 1967, and thot deoth occurred at 2:35 PM, from causes and on the date stated obave.

22a. SIGNATURE: John E. Everett M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/13/67
22c. PHYSICIAN'S NAME (Type): JOHN E. EVERETT
22d. ADDRESS: 9460 Conn. Ave Kensington

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 16, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. Mark's Cemetery
23d. LOCATION (City or Town) (County) (State): Fairland, Maryland

24. FUNERAL DIRECTOR: John B. Thomas Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUN 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08427

CERTIFICATE OF DEATH

08420

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b: 12 days.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Mont.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING 15
   d. STREET ADDRESS: 106 Rockdale Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AGNES — Middle O. — Last MAZUR

4. DATE OF DEATH: Month 6 — Day 24 — Year 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/18/92

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired.

10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE

11. BIRTHPLACE (County & State, or foreign country): D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDWARD DILLON

14. MOTHER'S MAIDEN NAME: JOHANNA GALLAGHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 219-46-9338

17. INFORMANT — Address: MARGARET M. DOYLE SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cerebral Edema — INTERVAL BETWEEN ONSET AND DEATH:
   DUE TO (b): Diabetic Acidosis
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Diabetes Mellitus
   260X

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from June 12, 1967 to June 24, 1967, that (I) (~~we~~) last saw the deceased alive on June 23 1967, and that death occurred at 3:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: Edward J. Richards M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-24-67

22c. PHYSICIAN'S NAME (Type): EDWARD J. RICHARDS

22d. ADDRESS: 10110 Ga. Ave. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6-28-67

23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEM.

23d. LOCATION (City or Town) (County) (State): SILVER SPRING MD.

24. FUNERAL DIRECTOR: Francis Collins — ADDRESS: 3321-14th St. N.W. Wash. D.C.

25a. REC'D BY REGISTRAR DATE: JUN 28 1967

25b. REGISTRAR'S SIGNATURE: Charles Lodge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08428

CERTIFICATE OF DEATH

08421

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SANITARIUM & HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 105 UNIVERSITY BLVD. E. APT. 201
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First MR. RALPH — Middle CHARLES — Last McCAULEY.

4. DATE OF DEATH: Month 6 — Day 14 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-25-41

9. AGE (In years last birthday): 26 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRICIAN

10b. KIND OF BUSINESS OR INDUSTRY: SILVER BURG ELECTRIC

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT McCAULEY

14. MOTHER'S MAIDEN NAME: EDITH ROSELE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WAVY '59-62

16. SOCIAL SECURITY NO.: 215-38-4337

17. INFORMANT: HOSPITAL RECORDS — Address

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Circulatory collapse — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): CUSHING'S ULCER — 48 hours
DUE TO (c): Ruptured saccular intracranial aneurysm — 1 hr.

330 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/5, 1967, to 6/14, 1967 that (I) ~~(we)~~ last saw the deceased alive on 6/13 1967 and that death occurred at 8:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: John T. Ford M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): John Thomas Ford

22d. ADDRESS: 1015 Spring St. Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/15/1967

23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL

23d. LOCATION (City or Town) (County) (State): SUITLAND, MD.

24. FUNERAL DIRECTOR: JAMES T. RYAN, Inc. — ADDRESS: 317 Pa. AVE., S.E.

25a. REC'D BY REGISTRAR DATE: JUN 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08429

CERTIFICATE OF DEATH

08424

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SPENCERVILLE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 15739 GOOD HOPE ROAD

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTG.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SPENCERVILLE 15,1
d. STREET ADDRESS: 15739 GOOD HOPE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jason — Middle: — Last: Mc Nalley
4. DATE OF DEATH: Month: June — Day: 15 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: ? 1885
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): GEROGIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: 212-14-3852
17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 443X Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO (b): Congestive heart failure — 2-3 days
DUE TO (c): Hypertensive Cardio-vascular disease — not known
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Recent cerebral thrombosis (C.V.A)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 9, 1967 to June 15, 1967, that (I) (we) last saw the deceased alive on June 14 1967, and that death occurred at 3:10 P.M., from causes and on the date stated above.

22a. SIGNATURE: John R Spencer M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-15-67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6/19/67
23c. NAME OF CEMETERY OR CREMATORY: ASH MEMORIAL CEM.
23d. LOCATION (City or Town) (County) (State): SANDY SPRINGS, MD

24. FUNERAL DIRECTOR — ADDRESS: ROBERT L. S NOWDEN ROCKVILLE, MD
25a. REC'D BY REGISTRAR — DATE: JUN 22 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

38430 — 08425

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
   c. LENGTH OF STAY IN 1b: 44 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Washington D.C. — b. COUNTY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C.
   d. STREET ADDRESS: 73 Adams [illegible] Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First Joseph — Middle A. — Last Meinberg
4. **DATE OF DEATH**: Month June — Day 2 — Year 19 67

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-25-91
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired electrician
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (County & State, or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? America USA

13. FATHER'S NAME: Adam Meinberg
14. MOTHER'S MAIDEN NAME: Mary La Port

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): Army--WWI
16. SOCIAL SECURITY NO.: 578-58-2312
17. INFORMANT: Mrs. Roger Comphre — Address: 7616 Georgia Avenue NW Washington, D C

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Stomach c Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 7 yr.
DUE TO (b):
DUE TO (c):
151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/19, 1967, to 6/2, 1967 that (I) (we) last saw the deceased alive on 6/1/67 19___, and that death occurred at 3:20 AM, from causes and on the date stated above.

22a. SIGNATURE: Raymond Olivet — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 2, 1967
22c. PHYSICIAN'S NAME (Type): Raymond O. West
22d. ADDRESS: 831 University Blvd. E., S. S., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 6, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR — ADDRESS: Glen Carter Oliver Carter 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: JUN 8 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

28431 — 08426

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 17 hr. 20 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster 21207
d. STREET ADDRESS: 182 Penna. Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillie — Middle: Ieene — Last: Meyers

4. DATE OF DEATH: Month: 6 — Day: 11 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-6-86

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emanuel Hollenbugh

14. MOTHER'S MAIDEN NAME: Elizabeth Null

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220-46-1990

17. INFORMANT — Address: Edward Crist - Brandon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial asthma + — INTERVAL BETWEEN ONSET AND DEATH: many yrs.
~~DUE TO~~
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: A S H D & congestive failure — several mos.
(c):
241X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from 6/10, 1967 to June 11, 1967, that ☒ (we) last saw the deceased alive on June 11 1967, and that death occurred at 9:58 A.M. from causes and on the date stated above.

22a. SIGNATURE: Marvin Wadler — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/11/67

22c. PHYSICIAN'S NAME (Type): MARVIN WADLER

22d. ADDRESS: 8218 Wisconsin Av. Bethesda

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-14-67

23c. NAME OF CEMETERY OR CREMATORY: Mudow Branch

23d. LOCATION (City or Town) (County) (State): Westminster Carrol. Md

24. FUNERAL DIRECTOR: Ernest C. Gartner — ADDRESS: Ernest C. Gartner Gaithersburg Md

25a. REC'D BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Yingst

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08432 08427

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 35 days

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: 4224 Oglethorpe St. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville, Md.
d. STREET ADDRESS: 4224 Oglethorpe St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Nursing Home

3. **NAME OF DECEASED** (Type or print): First: SARAH — Middle: M. — Last: MILLER

4. **DATE OF DEATH**: Month: 6 — Day: 5 — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 21, 1885

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.

10b. KIND OF BUSINESS OR INDUSTRY: — —

11. BIRTHPLACE (County & State, or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Van Buskirk

14. MOTHER'S MAIDEN NAME: Zeytka Burton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO

16. SOCIAL SECURITY NO. (If yes give war or dates of service): NONE — 5-7712-4753

17. **INFORMANT**: James R Seeders — Address: 8226 Bluford Rd. Kens. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure, acute — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.
(b): Coronary occlusion — 4 hrs.
DUE TO
(c): Arterio-sclerosis, gen'l — 10 yrs. ?

H20 1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Vascular accident - 7 w'ks

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Apr. 30, 19 67, to June 5, 1967, that (I) (we) last saw the deceased alive an June 5, 1967, and that death occurred at 11:37 p.m., from causes ond on the date stated above.

22a. SIGNATURE: Philip H. Varner, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-6-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: 10620 Georgia Ave, Wheaton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-8-1967

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION (City or Town) (County) (State): Prince Georges Co. Md.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. — ADDRESS: 5130 Wisc. Ave N.W. Wash. D.C.

25a. RECD BY REGISTRAR DATE: JUN 12 1967

25b. REGISTRAR'S SIGNATURE: [illegible], Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12 31 08428

08433

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OE STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: 436 E. Diamond Ave.
e. IS RESIDENCE ON A EARM? YES ☐ NO ☒

15.1

3. NAME OF DECEASED (Type or print): First: Eugene — Middle: Townsend — Last: Mitchell
4. DATE OF DEATH: Month: June — Day: 2 — Year: 1967
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/8/34
9. AGE (In years last birthday): 33 yrs.
IF UNDER 1 YEAR: Months / Days — IE UNDER 24 HRS.: Haurs / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bake-Shop
10b. KIND OE BUSINESS OR INDUSTRY: Safeway Stores
11. BIRTHPLACE (State ar foreign country): Virginia
12. CITIZEN OE WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hugh Mitchell
14. MOTHER'S MAIDEN NAME: Mabel Payne

15. WAS DECEASED EVER IN U.S. ARMED EORCES? (Yes, na, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-32-1320
17. INFORMANT: Wife-Ruth — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac tamponade
DUE TO (b): Due to perforation aorta and left atrium
DUE TO (c): Due to bullet wound heart
Conditians, if ony, which gove rise to immediote couse (a), stating the underlying couse last.
976 X
INTERVAL BETWEEN ONSET AND DEATH: Sudden.

PART II. OTHER SIGNIEICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PEREORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.): Shot self in chest - 22 cal. Pistol.
20c. TIME OF INJURY Manth, Day, Year: Hour a.m. 12.05 p.m. 6/2 1967
20d. INJURY OCCURRED While at wark ☐ Nat While at wark ☒
20e. PLACE OE INJURY (Home, farm, factary, street, office bldg., etc.): Home -
20f. (City or town) (County) (State): Gaithersburg Mont. Md.

21. I certify that I taak charge of the remains described abave, held an Autapsy ☒, Inspectian ☒, Inquiry ☒, and in my apinian death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 6/2/67
EXAMINER'S NAME (Type): John G. Ball --7936 Old Georgetown Road, Bethesda, Maryland
(Address (Street) (City, town or county))

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOE: 6/5/67
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City or Town) (County) (State): Rockville, Montg. Md.

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home
ADDRESS: 1331 Rockville Pike Rockville, Maryland
25a. REC'D BY REGISTRAR DATE: JUN 8 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be farwarded ta the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained far your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, ar removal, and in any event within 72 haurs after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08434 — 08429

CERTIFICATE OF DEATH

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda c. LENGTH OF STAY IN 1b: 12 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital	d. STREET ADDRESS: 301 Giddings Street e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First Middle Last: Gerry Ellis Monroe	4. DATE OF DEATH Month Day Year: June 17 1967
5. SEX: Male 6. COLOR OR RACE: Cauc 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH: 3 June 1967 9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months 00 Days 15 IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): Anne Arundel, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Gregory Eugene Monroe	14. MOTHER'S MAIDEN NAME: Mayrl J. Darm
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO.: None	17. INFORMANT Address: 301 Giddings Street, Gregory G. Monroe, Annapolis, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Tracheo-esophageal fistalue with extensive

DUE TO: aspiration pneumonitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Congenital Heart Disease

DUE TO

(c): Multiple congenital Anomalies

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5 June, 1967, to 17 June, 1967, that (I) (we) last saw the deceased alive on 17 June 1967, and that death occurred at 5:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: Ronald F. Swanger — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED: 18 June 1967
22c. PHYSICIAN'S NAME (Type): LCDR R. F. SWANGER, MC USN	22d. ADDRESS: Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 6-19-67	23c. NAME OF CEMETERY OR CREMATORY: Naval Academy Cemetery	23d. LOCATION (City or Town) (County) (State): Annapolis, Maryland

24. FUNERAL DIRECTOR: John M. Taylor & Sons ADDRESS: Md. Funeral Home, 147-149 Gloucester St., Annapolis	25a. REC'D BY REGISTRAR DATE: JUN 20 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08435 08430

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   d. STREET ADDRESS: 11802 Idlewood Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: John — Middle: H. — Last: Moore

4. **DATE OF DEATH**: Month: 6 — Day: 10 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/4/12

9. AGE (In years last birthday): 55 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Taxicab Driver.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Daniel R. Moore

14. MOTHER'S MAIDEN NAME: Alice M. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 579-01-9361

17. **INFORMANT** Address: Mrs. Doris B. Moore, 2a, b, c, d Above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Myocardial Infarction Acute. — INTERVAL BETWEEN ONSET AND DEATH: 4hrs.
   DUE TO
   4201
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Coronary Occlusion. Acute — 4hrs.
   DUE TO
   (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Ball M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 6/10/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12 Jun 1967

23c. NAME OF CEMETERY OR CREMATORY: Washington National Cem.

23d. LOCATION (City or Town) (County) (State): Suitland, Md.

24. FUNERAL DIRECTOR: Rinaldi Funeral Home, Inc.
ADDRESS: 7400 Georgia Ave Wash., D.C.

25a. RECD BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08436 08431

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corparote limits, write RURAL ond give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 59 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: Virginia
b. COUNTY: FAIRFAX
c. CITY OR TOWN (If autside carporote limits, write RURAL and give neorest town): ALEXANDRIA
d. STREET ADDRESS: 823 Empress Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lucy; Middle Cutts; Lost Moore
4. DATE OF DEATH: Month June; Day 17; Year 1967
5. SEX: Female
6. COLOR OR RACE: Cauc
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb.22 1920
9. AGE (In yeors last birthday): 47 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Haurs; Min.
10a. USUAL OCCUPATION (Give kind af work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): Massachusetts
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: E. F. Cutts
14. MOTHER'S MAIDEN NAME: E. Riles
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknown) No (If yes give war ar dotes of service)
16. SOCIAL SECURITY NO.: 049-18-7985
17. INFORMANT: Raymond A. Moore — Address: 523 Empress Court, Alexandria, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Infiltrating Carcinoma of Hypopharynx — INTERVAL BETWEEN ONSET AND DEATH
147 X
Conditians, if any, which gave rise to immediote couse (o), stoting the underlying couse last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I ar Part II af item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at wark ☐ Nat While at work ☐
20e. PLACE OF INJURY (Hame, farm, factory, street, office bldg., etc.)
20f. (City ar tawn) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 29, 1967, to June 17, 1967, that (I) (we) last saw the deceased alive an June 17 1967, and that death accurred at 7:55 AM, fram causes and an the date stated abave.

22a. SIGNATURE: T. D. Blanton M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): T. D. Blanton, MD
22d. ADDRESS: Naval Hospital, Bethesda, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 20
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City ar Town) (County) (State): Arlington Va.
24. FUNERAL DIRECTOR: Demaine Memorial Chapel, ADDRESS: 520 S. Washington St., Alexandria, Va.
25a. REC'D BY REGISTRAR DATE: JUN 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08437 08432

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Mongomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 11 hr. 50 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitorium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington Grove
d. STREET ADDRESS: 151
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dallas Middle: Estie Lost: Morris
4. DATE OF DEATH: Month: June Day: 13 Year: 1967
5. SEX: male
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-7-86
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Milton A. Morris
14. MOTHER'S MAIDEN NAME: [redacted] Eliza Ann Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 219-01-8131
17. INFORMANT Address: W.S.H Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): ACUTE MYOCARDIAL INFARCT — 12 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): LEFT SIDED CHF & CORONARY ARTERY DISEASE — 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITIS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 1:30 PM
20f. (City or town) (County) (State): 1:50 PM

21. I certify that (I) (this hospital) attended the deceased from 13 June, 1967, to 13 June 1967, that (I) (we) last saw the deceased olive on 13 JUNE 1967, and that death occurred at 1:50 PM, fram causes and on the date stated abave.

22a. SIGNATURE: John A. Ford M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-13-67
22c. PHYSICIAN'S NAME (Type): JOHN LOUIS FORD MD
22d. ADDRESS: 831 UNIVERSITY BLVD E SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-15-67
23c. NAME OF CEMETERY OR CREMATORY: Laytonsville
23d. LOCATION (City or Town) (County) (State): Laytonsville Md.

24. FUNERAL DIRECTOR ADDRESS: Francis H. Barber Laytonsville, Md.
25a. RECD BY REGISTRAR DATE: JUN 15 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08438 08433

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 23 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8925 BROOKVILLE ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING 15-1
d. STREET ADDRESS: 8925 BROOKVILLE ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle HARVEY Last MORSE

4. DATE OF DEATH: Month JUNE Day 4 Year 1967

5. SEX: MALE
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/18/1893
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GARAGE WORK
10b. KIND OF BUSINESS OR INDUSTRY: AUTOMOTIVE
11. BIRTHPLACE (State or foreign country): NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ROBERT MORSE I
14. MOTHER'S MAIDEN NAME: MARY ARMSTRONG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS. EMMA MORSE Address: AS ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	INFARCTION, ACUTE MYOCARDIAL - anterio-SEPTAL	5 HOURS
DUE TO (b)	CORONARY ARTERY ATHEROSCLEROSIS	5 YEARS
DUE TO (c)	GENERAL ATHEROSCLEROSIS INCLUDING MESENTERIC ARTERY	10 YEARS

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): MYOCARDIAL INFARCTION, CHRONIC

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/19 1960, to JUNE 4 1967, that (I) (we) last saw the deceased alive on JUNE 4 19 67, and that death occurred at 7:29 AM, from the causes and on the date stated above.

22a. SIGNATURE: James A. Roberts M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/4/67
22c. PHYSICIAN'S NAME (Type): JAMES A. ROBERTS
22d. ADDRESS: 8907 GEORGIA AVE SILVER SPRING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6/10/67
23c. NAME OF CEMETERY OR CREMATORY: Carver Mem. Park
23d. LOCATION (City, town, or county) (State): Laurel, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR DATE: JUN 8 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jenger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08433

CERTIFICATE OF DEATH

08434

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 1 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Randolph Wills Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
d. STREET ADDRESS: 2332 Glenmont Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Abraham — Middle: — Last: Moser

4. DATE OF DEATH: Month: June — Day: 20 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/21/1885

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Weight master

10b. KIND OF BUSINESS OR INDUSTRY: Marlow Coal Co.

11. BIRTHPLACE (County & State, or foreign country): XXXXXXXX Wash., D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Moser

14. MOTHER'S MAIDEN NAME: Fannie Breslau

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: Yes

17. INFORMANT: Joseph Moser — Address: 14113 Chelmsford Road, Rockville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO (b): Coronary artery Thrombosis — 1 month
DUE TO (c): Generalized arteriosclerosis — 15 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
H201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) ottended the deceased from 5/25, 1967, to 6/20, 1967, thot (I) (we) lost sow the deceased olive on 6 June 1967, and thot death occurred at 8:54 M, from couses ond on the date stoted above.

22a. SIGNATURE: Merton L. White — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 20 June 67

22c. PHYSICIAN'S NAME (Type): Merton L. White

22d. ADDRESS: 7911 Georgia Ave Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 23, 1967

23c. NAME OF CEMETERY OR CREMATORY: Parkalwn Cemetery

23d. LOCATION (City or Town) (County) (State): Rockville, Maryland

24. FUNERAL DIRECTOR: Paul D. Smith — ADDRESS: 8434 Georgia Avenue, Silver Spring, Md.
Warner L. Pumphrey, Inc.

25a. REC'D BY REGISTRAR DATE: JUN 26 1967

25b. REGISTRAR'S SIGNATURE: R. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Items 18-21 Film 390
7-13-67 ams

1 4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08440 08435

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. San + Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyatt. 16.2
d. STREET ADDRESS: 1409 Langley Way # 102
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HATTIE Middle G. Last NOKES
4. DATE OF DEATH: Month 6 Day 7 Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-6-~~XX~~ 73
9. AGE (In years last birthday) 93 ~~XX~~ yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Burgess
14. MOTHER'S MAIDEN NAME: ~~XXXXX~~ Elizabeth Bartlett
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 213-54-9513
17. INFORMANT: John Nokes / Hosp. record — Address: 1545 N. Faulkland Lane Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured skull with left temporal
DUE TO (b): subdural hematoma
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Deceased fell from stretcher in Emergency Room.
20c. TIME OF INJURY Month, Day, Year: Hour 7:50 a.m. p.m. 6-4 19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital
20f. (City or town) Takoma Park (County) Montg. (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Read M.D. M.D.
EXAMINER'S NAME (Type): BELDEN R. READ M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: JUNE 7, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 10, 1967
23c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery
23d. LOCATION (City or Town) Washington, D. C. (County) (State)

24. FUNERAL DIRECTOR: E. Glen Carter Glen Carter
ADDRESS: Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUN 12 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08441

CERTIFICATE OF DEATH

08436

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Silver Spring
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Wheaton
d. STREET ADDRESS: 12021 Viers Mill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Willard — Middle S. — Lost North

4. DATE OF DEATH: Month June — Doy 9, — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 10-22-97

9. AGE (In yeors lost birthdoy): 69 yrs.

IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock Broker & Realator

10b. KIND OF BUSINESS OR INDUSTRY: Realty

11. BIRTHPLACE (County & Stote, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William North

14. MOTHER'S MAIDEN NAME: Laura Mc Conaughy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service): None

16. SOCIAL SECURITY NO.: 177-14-2863

17. INFORMANT: Ida North — Address: 12021 Viers Mill Road Wheaton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 mo
DUE TO (b): Calcific Aortic Stenosis — 48 yr
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
DUE TO (c):
4211

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. I certify that (I) (this hospital) attended the deceased from 4/61, 19 66, to 6/9/, 19 67, that (I) (we) last saw the deceased alive on 6/9/, 19 67, and that death occurred at 7:30 A M, from causes and on the date stated above.

22o. SIGNATURE: Robert C. Macon — M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 6/9/67

22c. PHYSICIAN'S NAME (Type): Robert C. Macon

22d. ADDRESS: 809 Viers Mill Rd., Rockville, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify): Trans-burial

23b. DATE THEREOF: June 13, 1967

23c. NAME OF CEMETERY OR CREMATORY: Miami Memorial Cemetery

23d. LOCATION (City or Town) (County) (Stote): Miami, Florida

24. FUNERAL DIRECTOR: C. Glen Carter C. Glen Carter — ADDRESS: 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.

25o. REC'D BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08442

CERTIFICATE OF DEATH

08437

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. + Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Washington — b. COUNTY: D.C
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C
   d. STREET ADDRESS: 1669 Columbia Rd N.W.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Margaret — Middle: Augusta — Last: O'Brien

4. **DATE OF DEATH**: Month: June — Day: 15 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-3-83

9. AGE (In years last birthday): 84 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered Nurse

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward B. O'Brien

14. MOTHER'S MAIDEN NAME: Martha Jane Grace

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day.
DUE TO (b): Cerebral arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bleeding duodenal ulcer.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that ~~I~~ (this hospital) attended the deceased from 6-6, 1967, to 6-15, 1967, that ☒ (we) last saw the deceased alive on 6-15 1967, and that death occurred at 12:25 ~~A~~ P.M., from causes and on the date stated above.

22a. SIGNATURE: Deweh T. Kimble, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 6-15-67

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June.17.1967

23c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery

23d. LOCATION (City or Town) (County) (State): Alexandria Va.

24. FUNERAL DIRECTOR — ADDRESS: The Delemaine, Alexandria, Va.

25a. REC'D BY REGISTRAR DATE: JUN 21 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08443

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08438

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington.
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Cedar Lane.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland. b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington — 15.1
   d. STREET ADDRESS: 4402 Edgefield Rd
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Kenneth — Middle: Melvin — Last: O'Callaghan
4. **DATE OF DEATH**: Month: June — Day: 2 — Year: 1967
5. SEX: M.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/24/45
9. AGE (In years last birthday): 21 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Typewriter repairman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wash D C
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Edwin O'Callaghan, Jr
14. MOTHER'S MAIDEN NAME: Elizabeth Utz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Father — Address: Edwin O'Callaghan, Jr. Same as Item 2.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Head Injury Severe — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
823.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Lost control of car he was driving + struck Utility Pole
20c. TIME OF INJURY Month, Day, Year: Hour 11:50 a.m. 6/2 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) (County) (State): Kensington Mont. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): JOHN G. BALL
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 6/3/67
Address (Street, city, town, or county): Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-5-67
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Prince George County, Md.
24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY, Bethesda, Maryland
ADDRESS
25a. REC'D BY REGISTRAR DATE: JUN 8 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/67

15

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08444

CERTIFICATE OF DEATH

08439

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Montgomery Co. Hospital
c. LENGTH OF STAY IN 1b: 5 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Colonial Villa Conv. Home

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 4410 Oglethorpe St. Hyattsville Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Anna — Middle: Marjorie — Last: Osman

4. **DATE OF DEATH**: Month: 6 — Day: 6 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-22-12

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Hamburg Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry E. Geary

14. MOTHER'S MAIDEN NAME: Frances Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: Yes

17. **INFORMANT**: Edward Geary — Address: 4410 Oglethorpe St. Hyattsville, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): GLIOBLASTOMA — INTERVAL BETWEEN ONSET AND DEATH: 11 mos
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
1939

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): PROBABLE BRONCHOPNEUMONIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from JUNE, 1966 to 6 JUNE, 1967, that (I) (~~we~~) last saw the deceased alive on 5 JUNE 1967, and that death occurred at 12:34 AM, from causes and on the date stated above.

22a. SIGNATURE: Morrill C. Quinnam Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-6-67

22c. PHYSICIAN'S NAME (Type): MORRILL C. QUINNAM JR. MD

22d. ADDRESS: 831 UNIVERSITY BLVD. E. SILVER SPRING

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-burial

23b. DATE THEREOF: June 9, 1967

23c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery

23d. LOCATION (City or Town) (County) (State): Hamburg, Penna.

24. FUNERAL DIRECTOR: Clarke E. Wise — ADDRESS: 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md

25a. REC'D BY REGISTRAR — DATE: JUN 8 1967

25b. REGISTRAR'S SIGNATURE: [illegible], Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2d Film #G389 6/15/67 pc

08445

CERTIFICATE OF DEATH

08440

1. **PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 42 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6821 Winnepeg Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Edward	James	Osten	June	3	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	MARRIED ☒	4/21/12	55 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Editor	U.S. Air Force	South Dakota	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James J. Osten	Sarah Bethel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (WIFE) Address	
YES 1943 - 1946	485-05-9926	Mrs E. J. Osten	6821 Winnepeg Rd. Benesda, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hemorrhage, Cerebral, Spontaneous	4 hours
DUE TO (b)	Polyarteritis Nodosa	2 mos
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 1960 to 6-3, 1967 that (I) (we) last saw the deceased alive on 6-3 1967, and that death occurred on 6/3 2AM, from causes and on the date stoted above.

22a. SIGNATURE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
Herbert L. Tanenbaum M.D.				6-3-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Herbert L. Tanenbaum	4400 Conn Ave NW Wash DC.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
CREMATION	6/4/67	Lee Crematory	Washington D.C.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lee F.H., 300 9th St. N.E. Wash, DC.	JUN 6 1967	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08446 08441

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE
c. LENGTH OF STAY IN 1b: Mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): POTOMAC VALLEY N.H.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C.
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 47-3
d. STREET ADDRESS: 1316 NEW HAMPSHIRE, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CECELIA Middle ELIZABETH Last OTIS
4. DATE OF DEATH: Month JUNE Day 10 Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 7, 1886
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. - TEACHER
10b. KIND OF BUSINESS OR INDUSTRY: TEACHING
11. BIRTHPLACE (County & State, or foreign country): ST. PAUL, MINN.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ARTHUR G. OTIS
14. MOTHER'S MAIDEN NAME: CECELIA WHITACRE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: - -
17. INFORMANT: Address: ELIZ. DAVIES, 6624 RANNOCH RD., BETH. MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
491X
DUE TO
Conditions, if any, which gave rise to immediate couse (o), stoting the underlying couse lost.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o): Glioblastoma
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/28/67 19__ to 6/10/67 19__, that (I) (we) last saw the deceased alive on 6/10/67 19__, and that death occurred at 6:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Henry C. Scruggs M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/10/67
22c. PHYSICIAN'S NAME (Type): HENRY C. SCRUGGS M.D.
22d. ADDRESS: 5413 Cedar Lane Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE THEREOF: 6/10/67
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREM.
23d. LOCATION (City or Town) (County) (State): SUITLAND, MD.

24. FUNERAL DIRECTOR — ADDRESS: JOS. GAWLERIS SONS, 5130 WIS. AVE, N.W., WASH., DC
25a. REC'D BY REGISTRAR DATE: JUN 20 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08447 08442

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 24 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia
d. STREET ADDRESS: 1311 Fanshawe St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice — Middle: none — Last: Oxman
4. DATE OF DEATH: Month: 6 — Day: 9 — Year: 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-1-XXXX1894
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wilkesbarre, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Barnett Cohen
14. MOTHER'S MAIDEN NAME: Sarah Cohen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown). (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 714-09-9001
17. INFORMANT: Benjamin Oxman (husband) — Address: 1311 Fanshawe St. Phila. Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Insufficency Acute — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
(b): Cardio Vascular Disease — years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4301

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 6/10/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: JUNE 17, 1967
23c. NAME OF CEMETERY OR CREMATORY: MONTIFIORE CEMETERY
23d. LOCATION (City or Town) (County) (State): MONTGOMERY COUNTY PA.

24. FUNERAL DIRECTOR: Bernard Danzansky & Sons
ADDRESS: 3501-14th St.NW, Wash. DC.
25a. RECD BY REGISTRAR DATE: JUN 14 1967
25b. REGISTRAR'S SIGNATURE:

VR A15ME (5)
6M 1/67

08447

Pennsylvania

Holy Cross Hospital

White

Coronary Insufficiency Acute

Cardio Vascular Disease

John G. Bell

6/10/67

1967

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08448 08443

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
d. STREET ADDRESS: 8706 OLD GEORGETOWN RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: EMORY — Last: Pollock

4. DATE OF DEATH: Month: June — Doy: 21 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1/19/92

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Gov't

11. BIRTHPLACE (County & State, or foreign country): Wash D C

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George F Pollock

14. MOTHER'S MAIDEN NAME: Cora Lee Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-44-4829

17. INFORMANT: Wife — Grace A. Pollock — Address: Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): ruptured esophageal varices

DUE TO (c): cirrhosis, Laennec's

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

5811

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from June 14, 1967 to June 20, 1967, thot (I) (we) last saw the deceased olive on June 20 1967 ond thot death occurred at 2:15 A.M., from couses ond on the dote stoted above.

22a. SIGNATURE: V.C. deGuzman — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 21, 1967

22c. PHYSICIAN'S NAME (Type): VICENTE deGUZMAN

22d. ADDRESS: 1234 19 NW Wash DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-23-67

23c. NAME OF CEMETERY OR CREMATORY: Monocacy Cemetery

23d. LOCATION (City or Town) (County) (State): Beallsville, Maryland

24. FUNERAL DIRECTOR — ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland

25a. REC'D BY REGISTRAR — DATE: JUN 22 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

Items 18&21 film 390 7-11 67 ans

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08443

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08444

1. **PLACE OF DEATH**
   a. COUNTY: MONTGOMERY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): KENSINGTON
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 10003 THORNWOOD RD

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
   c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): KENSINGTON 15-1
   d. STREET ADDRESS: 10003 THORNWOOD RD
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First DOROTHY — Middle — Lost POSTEL

4. **DATE OF DEATH**: Month JUNE — Doy 24 — Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/12/11

9. AGE (In yeors lost birthday): 55 yrs.

IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (Stote or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: GEORGE F. DEISER

14. MOTHER'S MAIDEN NAME: NELLIE J. JENKINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.

17. **INFORMANT** Address: MISS EDITH W. JENKINS - 705 - 18" ST. N.W. WASHINGTON, D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fatty Metamorphosis of liver, acute-
581.1
DUE TO
(b): Chronic and acute alcoholism
DUE TO
(c):
Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse lost.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I taak charge of the remains described abave, held an Autapsy ☐, Inspectian ☐, Inquiry ☐, and in my apinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S Ball M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. **DATE SIGNED** 6/26/67.

23a. ~~BURIAL~~, CREMATION, ~~REMOVAL~~ (Specify)

23b. DATE THEREOF 6-30-67

23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREMATORY

23d. LOCATION (City or Town) SOUTHLAND - (County) (State) MD.

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY ADDRESS 7557 WISCONSIN AVE. BETHESDA, MD.

25a. REC'D BY REGISTRAR DATE JUL 3 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G390 7/1/67 pc

08450

CERTIFICATE OF DEATH

08445

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 30 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3510 Salem Way Bethesda Md

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 15.1
d. STREET ADDRESS: 3510 Salem Way
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gertrude Middle: Loretta Last: Power

4. DATE OF DEATH: Month: 6 Day: 24 Year: 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 10 1905

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: US Goverment

11. BIRTHPLACE (County & State, or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: James M Power

14. MOTHER'S MAIDEN NAME: Loretta C Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): NONE

16. SOCIAL SECURITY NO.: 220-46-2054

17. INFORMANT: James E Power
Address: 414 Prospect St Seattle Wash 918109

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Squamous carcinoma of Pharynx
DUE TO (b): with neck node Metastasis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1148X

INTERVAL BETWEEN ONSET AND DEATH: 6 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 2/24, 1967, to 6/24, 1967, that (I) (~~we~~) last saw the deceased alive on 6/23 1967, and that death occurred at 7 A M, from causes and on the date stated above.

22a. SIGNATURE: Frederick Y Donn
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/29/67

22c. PHYSICIAN'S NAME (Type): Frederick Y. DoNN

22d. ADDRESS: 10400 Connecticut Ave, Kensington Md

23a. BURIAL, CREMATION, REMOVAL: Burial

23b. DATE THEREOF: 6-28-67

23c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery

23d. LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR: Robert A Pumphrey
ADDRESS: 7557 Wisc Ave. Bethesda, Md

25a. REC'D BY REGISTRAR DATE: JUL 3 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

Items 18&21 Film 390 7-21-67

1 10

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08451

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08446

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. San + Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 209 Southampton Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: B. — Last: Rappaport

4. DATE OF DEATH: Month: 6 — Day: 11 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 4-25-1923
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owners.
10b. KIND OF BUSINESS OR INDUSTRY: Bookstore
11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: SAMUEL RAPPAPORT
14. MOTHER'S MAIDEN NAME: JENNIE WEISS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 579-28-2443
17. INFORMANT: JOSEPH RAPPAPORT — Address: 7667 MAPLE AVE. TAKOMA PARK, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial dis. — INTERVAL BETWEEN ONSET AND DEATH: 7½ hrs.
DUE TO
(b): Chronic myocardial dis. — Yrs.
DUE TO
(c): Coronary atherosclerosis — Yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Rogers M.D.
EXAMINER'S NAME (Type): John S. Rogers M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): 1918 Seminary Rd. Silver Spring Md.
22. DATE SIGNED: June 11, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6-12-67
23c. NAME OF CEMETERY OR CREMATORY: GEO. WASH. CEM.
23d. LOCATION (City or Town) (County) (State): HYATTSVILLE PG. MD

24. FUNERAL DIRECTOR: GOLDBERG FUNERAL HOME — ADDRESS: 4217 9TH ST. N.W.
25a. RECD BY REGISTRAR DATE: JUN 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Juggs

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08452

CERTIFICATE OF DEATH

08447

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b: 5 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): 1805 Tunis Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Silver Spring
   d. STREET ADDRESS: 1805 Tunis Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella — Middle: Traynor — Lost: Ray

4. DATE OF DEATH: Month: 6 — Doy: 29 — Year: 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Apr 7, 1864

9. AGE (In years last birthday): 103 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Traynor

14. MOTHER'S MAIDEN NAME: Mary Jane Champion

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No — None

16. SOCIAL SECURITY NO.: Yes

17. INFORMANT: Laura J. Renshaw — Address: 1805 Tunis Road Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Generalized Arteriosclerosis
   DUE TO (b): Senility
   Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
   DUE TO (c):
   4500
   INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from June, 1967 to June, 1967, that (I) (~~we~~) last saw the deceased alive on 6-24 1967, and that death occurred at 6:45 AM, from causes and on the date stated above.

22a. SIGNATURE: Bernard A Fitzgerald — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-29-67

22c. PHYSICIAN'S NAME (Type): BERNARD A FITZGERALD

22d. ADDRESS: 217 Wayne Blvd E. Silver Sp. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 1, 1967

23c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery

23d. LOCATION (City or Town) (County) (State): Washington, D. C

24. FUNERAL DIRECTOR: C. Glen Carter / Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: JUN 30 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08453

CERTIFICATE OF DEATH

08448

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 7 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 4401 East West Higheay
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ROSE — Middle: Catherine — Last: RAYMOND

4. DATE OF DEATH: Month: June — Day: 26 — Year: 19 67

5. SEX: Female ~~Male~~

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Aug 20, 1889

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Schirmer

14. MOTHER'S MAIDEN NAME: Catherine Nagengast

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No — None

16. SOCIAL SECURITY NO.: 577-30-7227-B

17. INFORMANT: George Raymond — Address: 313 Lexington Drive Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac shock — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

DUE TO (b): Acute myocardial infarction — 48 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 15, 19 67, to June 26, 19 67, that (I) (we) last saw the deceased alive on June 24 19 67, and that death occurred at 11:45 A.M., from causes and on the date stated above.

22a. SIGNATURE: Marvin Wadler — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 26, 67

22c. PHYSICIAN'S NAME (Type): MARVIN WADLER

22d. ADDRESS: 8218 Wisc. Ave Beth, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 30, 1967

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Suitland, Maryland

24. FUNERAL DIRECTOR: Glen Carter Conley — Warner E. Pumphrey, Inc.

ADDRESS: 8434 Georgia Avenue Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: JUN 29 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

Items 18-21 Film #391
8-11-67 mt

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08454 08449

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): SUBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Kensington, Md. - 15-1
d. STREET ADDRESS: 3224 Geiger St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle MARGARET Lost Reeve
4. DATE OF DEATH: Month June Doy 20 Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: Feb 7, 1922
9. AGE (In years lost birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper
10b. KIND OF BUSINESS OR INDUSTRY: Metal Mfg. Co.
11. BIRTHPLACE (Stote or foreign country): Jackson Center, Ohio
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ORLAD ROGERS - Deceased
14. MOTHER'S MAIDEN NAME: Cecile Linson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes give wor or dotes of service): None
16. SOCIAL SECURITY NO.: 295-22-6102
17. INFORMANT: Claude L. Reeve — Address: 3224 Geiger Street Kensington, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Concentric Hypertrophy of Heart with
DUE TO (b): Cardiac Arrhythmia
DUE TO (c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
434.4
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.
EXAMINER'S NAME (Type): BELDEN R. REAP M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, City, Town, or county): Gaithersburg
22. DATE SIGNED: 6/20/1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 23, 1967
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City or Town) (County) (State): Rockville, Maryland

24. FUNERAL DIRECTOR: C. Glen Carter Glen Carter Co. ADDRESS: 8434 Georgia Avenue Silver Spring, Maryland
Warner E. Pumphrey, Inc.

25a. REC'D BY REGISTRAR: JUN 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Items 18&21 Film 389
6-19-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 321 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #390 6/23/67 pc

FOR STATE HEALTH DEPT. 08455

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08450

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL
c. LENGTH OF STAY IN 1b: DOA

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
d. STREET ADDRESS: 5315 MC KINLEY STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NAVAL HOSPITAL, BETHESDA, MD.

3. NAME OF DECEASED (Type or print): First MARGARET Middle RHODES Last RICHARDSON

4. DATE OF DEATH: Month JUNE Day 6 Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT 2, 1905

9. AGE (In years last birthday): 62 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WASHINGTON, D. C.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: FRANK ROLAND RHODES

14. MOTHER'S MAIDEN NAME: EMMA PATRICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: JOHN H. RICHARDSON Address: SAME AS 2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): /Pending/ Broncho pneumonia left lower lobe — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO (b): Hypertensive cardiovascular disease — Years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
443 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): JOHN G. BALL, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 6-8-1967
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory
23d. LOCATION (City or Town) (County) (State): Prince Georges Co. Md.

24. FUNERAL DIRECTOR: Joseph Gawler & Sons
ADDRESS: 5130 Wisconsin Ave. N.W., Washington, D.C.

25a. REC'D BY REGISTRAR DATE: JUN 12 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Juaire

VR A15ME (5)
6M 1/67

Joseph Dwyer Lyons
5130 Nebraska Ave., N.W., Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08456 08451

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home — Potomac Valley Nursing and Convalescent

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 7009 Georgia Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OSCAR — Middle: Willis — Last: RILEY
4. DATE OF DEATH: Month: June — Day: 5 — Year: 19 67
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 7, 1894
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Wash. Terminal Co.
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Peter Jackson Riley
14. MOTHER'S MAIDEN NAME: Willie Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 718-14-9172
17. INFORMANT: Ruth H. Riley — Address: 7009 Georgia Street Chevy Chase, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO (b): Generalized Arteriosclerosis — 3 yrs
DUE TO (c): Unspecified
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Arteriosclerosis with Rt Hemiplegia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 1955, 19___, to 6/5, 1967, that (I) (~~we~~) last saw the deceased alive on 5/31, 1967, and that death occurred at 6:55 P.M., from causes and on the date stated above.

22a. SIGNATURE: Alexander C. Leonardo — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/5/67
22c. PHYSICIAN'S NAME (Type): Alexander C. Leonardo
22d. ADDRESS: 5801 13th St., N. W., Washington, D C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 7, 1967
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Prince Georges Co., Md.

24. FUNERAL DIRECTOR: Glen Carter — Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR: DATE JUN 8 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08457 — 08452

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b: 11 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Colonial Villa Nurs. Home 12325 N. Hamp Ave

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md
   b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
   d. STREET ADDRESS: 14808 Carrolton Rd
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Ralph — Middle: Potter — Last: Ripley

4. **DATE OF DEATH**: Month: 29 June — Day — Year: 19 67

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 5 1891

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): REAL ESTATE

10b. KIND OF BUSINESS OR INDUSTRY: Realtor

11. BIRTHPLACE (County & State, or foreign country): Amsterdam New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ernest Ripley

14. MOTHER'S MAIDEN NAME: Blanche Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 579-01-2231A

17. **INFORMANT**: Mrs. Merle Ripley — Address: 14808 Carrolton Rd. Rockville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: one day
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
H91X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this ~~hospital~~) attended the deceased from 6-19, 1967, to 6-27, 1967, that (I) (~~we~~) last saw the deceased alive an 6-29. 1967, and that death occurred at 10:30 PM, from causes and on the date stated above.

22a. SIGNATURE: R H Sandstrom M.D. — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☑ STAFF PHYS. ☐

22b. DATE SIGNED: 6-29-67

22c. PHYSICIAN'S NAME (Type): R. H. Sondstrom M.D.

22d. ADDRESS: 7701 Carroll Ave Takoma Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: June 30, 1967

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory

23d. LOCATION (City or Town) (County) (State): Prince Georges Co., Md.

24. FUNERAL DIRECTOR — ADDRESS: John B. Thomas Charles Thomas 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: JUL 3 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Junge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08458 08453

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery County — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Olney
   c. LENGTH OF STAY IN 1b: 46 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sharon Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 151
   d. STREET ADDRESS: 12728 Gould Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Elizabeth — Middle: Beatrice — Last: Robertson

4. **DATE OF DEATH**: Month: June — Day: 19 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Cauc.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 6 1896

9. AGE (In years last birthday): 71 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Statistical Clerk

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11. BIRTHPLACE (County & State, or foreign country): Georgia Polk County

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wesley Henley

14. MOTHER'S MAIDEN NAME: Mary Forsythe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service): No — None

16. SOCIAL SECURITY NO.: 577-60-2664

17. INFORMANT: Virginia R. Watterson — Address: 506 Linthicum St. Rockville, Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory insufficiency	2 hr.
DUE TO (b)	Cerebrovascular accident	2 wk
DUE TO (c)	Hypertensive Cardiovascular disease	Yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 2

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6/18/67 to 6/19/67, that (I) (we) last saw the deceased alive on 6/19/1967, and that death occurred at 7:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/19/67

22c. PHYSICIAN'S NAME (Type): C. H. Higgon

22d. ADDRESS: Sandy Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-burial

23b. DATE THEREOF: June 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Macon, Georgia

24. FUNERAL DIRECTOR'S SIGNATURE: John B. Thomas — ADDRESS: 8434 Georgia Avenue

Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR — DATE: JUN 22 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1S (4)
20M 5-63

Items 18-21 Film 390 7-13 67 ans

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08453 08454

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR A15ME (5) 6M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: PRINCE GEO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEWISDALE
d. STREET ADDRESS: 2211 AMHERST Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: (NM) — Last: ROGERS

4. DATE OF DEATH: Month: 6 — Day: 3 — Year: 1967

5. SEX: MALE — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 10-27-17 — 9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter — 10b. KIND OF BUSINESS OR INDUSTRY: Hardware — 11. BIRTHPLACE (State or foreign country): South Carolina — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: SIDNEY ROGERS — 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Address: MRS KAREN ROGERS (Wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple skull fractures with — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): intracranial hemorrhage due to fall
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
900.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Deceased fell down stairs at home
20c. TIME OF INJURY Month, Day, Year: 6-3-1967 — Hour: 6:45 p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Lewisdale Pr.Geo. Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒; and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Ketz M.D.
EXAMINER'S NAME (Type): BELDEN R. KETZ M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Bowie
22. DATE SIGNED: June 4, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: June 6-1967 — 23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln — 23d. LOCATION (City or Town) (County) (State): Hyattsville Pr.Geo. Md.

24. FUNERAL DIRECTOR: Arthur Walters — ADDRESS: 254 Carroll St. N.E.
25a. RECD BY REGISTRAR DATE: JUN 6 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Items 18-21 Film 390 7-13-67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08460

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08455

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Holy Cross Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg
   d. STREET ADDRESS: 4a4 58th Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Lori — Middle: T. — Last: Rogers

4. **DATE OF DEATH**: Month: June — Day: 4 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/21/66

9. AGE (In years lost birthday) 8 mos yrs

IF UNDER 1 YEAR: Months: 8 — Days: 13

IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Wash. D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: David Rogers

14. MOTHER'S MAIDEN NAME: Marlene C. ROSENberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. **INFORMANT** Address: Hosp RECORDS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Cerebral Contusion
DUE TO and
(b): Subarachnoid Hemorrhage
DUE TO
(c): due to fall
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
902.0

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
Deceased infant fell from sofa to floor.

20c. TIME OF INJURY Month, Doy, Year: 1130 Hour a.m. p.m. 6-1 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Bladensburg PrGeo Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R Reap M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): BELDEN R. REAP, M.D.

Address (Street, city, town, or county): Hyattsville

22. **DATE SIGNED**: June 4, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY-6-67

23c. NAME OF CEMETERY OR CREMATORY: Mt. MORIAH CEM

23d. LOCATION (City or Town) (County) (State): FAIRVIEW - N.J.

24. FUNERAL DIRECTOR: B Danzansky & Sons — ADDRESS: 3501 - 14th St. N.W.

25a. REC'D BY REGISTRAR DATE: JUN 6 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

6-7-67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08461 — 08456

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest tawn): Bethesda
c. LENGTH OF STAY IN 1b: 25 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Naval Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Arlington
d. STREET ADDRESS: 4922 Chesterfield Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ruby — Middle Ruth — Lost Ross

4. DATE OF DEATH: Month June — Doy 17 — Year 1967

5. SEX: Female
6. COLOR OR RACE: Cauc
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7 April 1912
9. AGE (In yeors last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): Lampassas, Texas
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John D. White
14. MOTHER'S MAIDEN NAME: Mary Katherine Hinkle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No
16. SOCIAL SECURITY NO.: 455-07-8650
17. INFORMANT: Joe K. Ross — Address: 4922 S. Chesterfield Road, Arlington, Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Carcinoma of the Colon — INTERVAL BETWEEN ONSET AND DEATH
1538
DUE TO
Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from 23 May, 1967, to 17 June, 1967, thot (I) (we) last saw the deceased alive on 17 June 1967, and that deoth occurred at 10:30 PM, from couses ond on the date stated above.

22o. SIGNATURE: William M. Hix — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 18 June 1967
22c. PHYSICIAN'S NAME (Type): LCDR W. R. HIX, MC USN
22d. ADDRESS: Naval Hospital, Bethesda, Maryland

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-21-67
23c. NAME OF CEMETERY OR CREMATORY: Bellwood Cemetery
23d. LOCATION (City or Town) (County) (State): Temple, Texas

24. FUNERAL DIRECTOR: Everely-Wheatly Funeral Home, Alexandria, Va.
ADDRESS: 1500 W. Braddock Rd
25a. REC'D BY REGISTRAR DATE: JUN 21 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08462

CERTIFICATE OF DEATH

08457

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 11017 Norde Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Judith — Middle: E — Last: Rubin

4. DATE OF DEATH: Month: June — Day: 14 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 26, 1929

9. AGE (In years last birthday): 37 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Jacob Weinberg

14. MOTHER'S MAIDEN NAME: Eva Edlavitch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 218-28-8330

17. INFORMANT Address: Albert S. Rubin - Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Metastases — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): 170X Adenocarcinoma of Breast — 24 yrs
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from March, 1967, to 6/14, 1967, that (I) ~~(we)~~ last saw the deceased alive on 6/13 1967, and that death occurred at 2:35 A M, from causes and on the date stated above.

22a. SIGNATURE: G. Leonard Gold, BH. Eiq, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/14/67

22c. PHYSICIAN'S NAME (Type): G. Lenard Gold BH. Eiq

22d. ADDRESS: 8641 Colesville Rd. Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 16, 1967

23c. NAME OF CEMETERY OR CREMATORY: Kneseth Israel Cem.

23d. LOCATION (City or Town) (County) (State): Annapolis Anne Arundel Md.

24. FUNERAL DIRECTOR: Beverley E. Hopping — ADDRESS: Beverley E. Hopping
HOPPING FUNERAL HOME - Annapolis, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08463

CERTIFICATE OF DEATH

08458

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: (PARENTS ADDRESS) MD. — b. COUNTY: HOWARD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELLICOTT CITY
d. STREET ADDRESS: ROUTE 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
BABY GIRL	--	RUSSO	JUNE	17	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
FEMALE	WHITE	NEVER MARRIED [X]	JUNE 17, 1967	- yrs.	-	-	8	30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		MONTGOMERY, Co., MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
AUGUST JOHN RUSSO, JR.	JOAN MARIE COLLINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
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MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6/17, 1967, to _____, 19___, that (I) (we) last saw the deceased alive on 6/17 1967, and that death occurred at 9 A M, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. [X] MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
L.S. Batman		6-17-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
DR. LOUISA S. BATMAN, M. D.	PROFESSIONAL BUILDING, DAMASCUS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6-18-67	Laytonsville	Laytonsville Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Francis H. Barber	Laytonsville, Md.	JUN 22 1967	J. Charles Judge

7-231869

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08464

CERTIFICATE OF DEATH

08459

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn): Silver Spring
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address): 1517 Forest Glen Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Mass.
b. COUNTY: Middlesex
c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn): Waltham
d. STREET ADDRESS: 81 Middlesex Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type ar print): First: Dennis — Middle: J — Last: Ryan

4. DATE OF DEATH: Month: June — Day: 14 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec 12, 1875

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Haurs / Min.

10a. USUAL OCCUPATION (Give kind af wark dane during most af working life, even if retired): Retired Mail Carrier

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11. BIRTHPLACE (Caunty & State, ar fareign country): Newton, Mass.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Ryan

14. MOTHER'S MAIDEN NAME: Mary Kennedy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war ar dates af service): None

16. SOCIAL SECURITY NO.: 034-12-3850

17. INFORMANT: Address: 1479 Wash St.
Thomas J. Lyons Funeral Home - W. Newton, Ma

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly ane cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b): Coronary artery sclerosis
DUE TO (c):
Canditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: minutes — —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Haur a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, affice bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 6/8/, 1967, to 6/14, 1967, that (I) (~~we~~) last saw the deceased alive an 6/13 1967, and that death accurred at 6:41 M, fram causes and an the date stated abave.

22a. SIGNATURE: R C Kirchner — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-14-67

22c. PHYSICIAN'S NAME (Type): Raymond C. Kirchner

22d. ADDRESS: 6480 New Hampshire Ave, Takoma Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Trans

23b. DATE THEREOF: June 17, 1967

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City ar Tawn) (County) (State): Waltham, Mass.

24. FUNERAL DIRECTOR: John B. Thomas / Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: JUN 15 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

1 4

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08465

CERTIFICATE OF DEATH

08468

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)
c. LENGTH OF STAY IN 1b 21 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island 08.2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mary Middle Lillian Last SARACINO

4. DATE OF DEATH Month June Day 12 Year 19 67

5. SEX Female

6. COLOR OR RACE Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH February 20,1903

9. AGE (In years last birthday) 64 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edward Ignatius Downs

14. MOTHER'S MAIDEN NAME Frances Gaffney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Cobb Island Address Maryland
BMC pasquale Saracino, USN, Ret.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from May 22, 19 67, to June 12, 19 67 that (X) (we) last saw the deceased alive on June 12 19 67, and that death occurred at 0900 AM from causes and on the date stated above.

22a. SIGNATURE D. R. Foreman

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED 13 June 1967

22c. PHYSICIAN'S NAME (Type) D. R. Foreman, LT, MC, USN

22d. ADDRESS Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 6/16/1967

23c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery

23d. LOCATION (City or Town) (County) (State) Issue, Maryland

24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. ADDRESS LaPlata, Maryland

25a. REC'D BY REGISTRAR DATE JUN 16 1967

25b. REGISTRAR'S SIGNATURE J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08466

CERTIFICATE OF DEATH

08461

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville, Maryland
d. STREET ADDRESS: 4600 Harlan Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dina — Middle: — Last: Sazonoff

4. DATE OF DEATH: Month: June — Day: 14 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/15/88

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: (unknown) Bassman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 127-14-6241A

17. INFORMANT: Vivian Sande — Address: 2116 F. Street, N. W. Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO (b): Ascvd.
DUE TO (c): Oldage.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
4201

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senual Debilitation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or Town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1, 1967 to June 14, 1967 that (I) (we) last saw the deceased alive an June 14 1967, and that death occurred at 10 A M, from couses and on the date stated obave.

22a. SIGNATURE: R.C. Bufalino M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: June 14, 1967

22c. PHYSICIAN'S NAME (Type): R.C. Bufalino, M.D.

22d. ADDRESS: 1929 University Blvd W. Silver Spring

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: June 15, 1967

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory

23d. LOCATION (City or Town) (County) (State): Prince Georges Co., Md.

24. FUNERAL DIRECTOR: John B. Thomas, Warner E. Pumphrey, Inc.

ADDRESS: 8434 Georgia Avenue Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: JUN 15 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

Items 18-21 Film 390 7-17 ms

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08467 08462

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 7½ hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: New York
b. COUNTY: Broome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Endicott
d. STREET ADDRESS: 321 Robble Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Patsy Middle: Frank Last: Sbarra

4. DATE OF DEATH: Month: June Day: 21 Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-31-94

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Liquor Store Owner - Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: ? Sbarra

14. MOTHER'S MAIDEN NAME: Rachell Cinotti

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): yes Army WW1

16. SOCIAL SECURITY NO.: 096-01-6085

17. INFORMANT: Patient's chart Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute hemipericardium — INTERVAL BETWEEN ONSET AND DEATH: 8½ hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 825.9
(b): Hemorrhage great vessels at base of heart — 8½ hrs.
DUE TO
(c): Chest injury — 8½ hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Was found in wrecked car on street

20c. TIME OF INJURY Month, Day, Year: Hour 6:30 a.m. p.m. June 20 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town) (County) (State): Hyattsville Pr.George Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Rogers M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): John S. Rogers M.D.
Address (Street, city, town, or county): 1919 Seminary Rd. Silver Spg. Md.

22. DATE SIGNED: June 21, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/24/67
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d. LOCATION (City or Town) (County) (State): Silver Spring, Md.

24. FUNERAL DIRECTOR: Nalley's Funeral Home Inc.
ADDRESS: Mt. Rainier Maryland
25a. REC'D BY REGISTRAR DATE: JUN 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

Still Pending 7/13 -

589-1645

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08468

CERTIFICATE OF DEATH

08463

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda,
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gapland
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mattie — Middle: I — Last: SCHAFER

4. DATE OF DEATH: Month: June — Day: 28 21 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 10, 1892

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Cedar Grove, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Greenberry Eyler

14. MOTHER'S MAIDEN NAME: Melvina Biddinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service)

16. SOCIAL SECURITY NO.: 244-14-8208

17. INFORMANT — Address: Mr. A. Irving Schafer, Gapland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intestinal Obstruction due to unknown cause — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this haspital) attended the deceased from June 20, 19 67, to June 21, 19 67, that (I) (we) last saw the deceased alive an June 21 19 67, and that death accurred at 725 P M, fram causes and an the date stated above.

22a. SIGNATURE: R. J. Kinney M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 22 June 1967

22c. PHYSICIAN'S NAME (Type): R. J. KINNEY M. D.

22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/24/67

23c. NAME OF CEMETERY OR CREMATORY: Rocky Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Woodsboro, Md.

24. FUNERAL DIRECTOR: Barton Funeral Home — ADDRESS: Walkersville, Md.

25a. REC'D BY REGISTRAR DATE: JUN 27 1967

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Items 18-21 Film 390
7-11-67 ams

1 8

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08463 08464

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 27 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11022 Lockwood Dr.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 11022 Lockwood Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First C. Middle Bailey Last Scrimgeour
4. DATE OF DEATH: Month 6 Day 1 Year 1967
5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 4, 1899
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired engineer
10b. KIND OF BUSINESS OR INDUSTRY: Contractor
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William M. Scrimgeour
14. MOTHER'S MAIDEN NAME: Lula Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give wor or dates of service) None
16. SOCIAL SECURITY NO.: 579-44-8142
17. INFORMANT: Maxwell Scrimgeour — Address: 11020 Lockwood Dr. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxiation due to carbon monoxide — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): intoxication, and generalized third
DUE TO
(c): degree burns
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
916.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.): Deceased burned in house fire.
20c. TIME OF INJURY Month, Day, Year: 1 58 Hour o.m. p.m. 6-1 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Silver Spring Montg. Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden Reap, M.D.
EXAMINER'S NAME (Type): Belden Reap, D. M. E. Wheaton, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Wheaton
22. DATE SIGNED: June 2, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 3, 1967
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Suitland, Maryland

24. FUNERAL DIRECTOR: C. Glen Carter — ADDRESS: 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUN 8 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18-21 Film 390 7-1 [illegible]

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08470

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08465

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 27 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11022 Lockwood Dr.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 11022 Lockwood Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Evelyn — Middle: Thornton — Last: Scrimgeour

4. DATE OF DEATH: Month: 6 — Day: 1 — Year: 1967

5. SEX: ~~Female~~ Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: May 21, 1902

9. AGE (In years lost birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ~~XXXXXX~~ Walter Thornton

14. MOTHER'S MAIDEN NAME: Kate Waddington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — None

16. SOCIAL SECURITY NO.: 216-46-2763

17. INFORMANT: William Scrimgeour — Address: 4832 Oxford Dr., S. E. Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized third degree burns with
DUE TO (b): asphyxia due to smoke and heat inhalation
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
916.0

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.): Deceased burned in house fire.

20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. 1:58 — 6-1 — 1967

20d. INJURY OCCURRED While at work ☐ — Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Silver Spring — Montg — Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden Reap, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Belden Reap — Address (Street, city, town, or county): Wheaton, Md.

22. DATE SIGNED: June 2, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 3, 1967

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Suitland, Maryland

24. FUNERAL DIRECTOR Glen Carter — Colin Carter — Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: JUN 8 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08471

CERTIFICATE OF DEATH

08466

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 69 MONTG. GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney 1501
d. STREET ADDRESS: Mt. Zion Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joshua — Middle: M. — Last: Selby

4. DATE OF DEATH: Month: June — Day: 10 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/31/87

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farm work

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (County & State, or foreign country): Montgomery County, Md.

12. CITIZEN OF WHAT COUNTRY? yes U.S.A.

13. FATHER'S NAME: Joshua Selby

14. MOTHER'S MAIDEN NAME: Christine Budd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT — Address: Montgomery General Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL DISEASE — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b): ASCHD — H.C.V.D — 1 YRS.
DUE TO (c): GENERALIZED ARTERIOSCLEROSIS — YRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4H3X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 2 CHRONIC CONGESTIVE HEART FAILURE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August, 19 67 to 6/10, 1967 that (I) (we) last saw the deceased alive on 6/5, 1967 and that death occurred at 2:15 P.M. from causes and on the date stated above.

22a. SIGNATURE: Donald R. Lewis — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/10/67

22c. PHYSICIAN'S NAME (Type): Donald R. Lewis, M. D.

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6/14/67

23c. NAME OF CEMETERY OR CREMATORY: MT ZION CEMETERY

23d. LOCATION (City or Town) (County) (State): MT. ZION, MONTG. MD.

24. FUNERAL DIRECTOR — ADDRESS: George P. Armiger Rockville

25a. REC'D BY REGISTRAR DATE: JUN 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Gregg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

CASE CLEARED WITH MEDICAL EXAMINER Harris

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08472

CERTIFICATE OF DEATH

08467

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 193 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gettysburg
d. STREET ADDRESS: R.D. #5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Theresa — Middle: Ann — Last: Shanebrook

4. DATE OF DEATH: Month: June — Day: 27, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 28 February 1943

9. AGE (In years last birthday): 24 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Earl A. McMaster

14. MOTHER'S MAIDEN NAME: Jane Weaver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service): ---

16. SOCIAL SECURITY NO.: 198-32-9698

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda, Maryland 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48 Hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Lymphosarcoma with acute lymphocytic leukemia — 12 Months
DUE TO
(c):

200.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from December 12 1966, to June 27, 1967, that ☒ (we) last saw the deceased alive an June 27 1967, and that death occurred at 6:45 AM, from causes and on the date stated above.

22a. SIGNATURE: Myron J. Levin — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 27 June 1967

22c. PHYSICIAN'S NAME (Type): Myron J. Levin, MD.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 30 June 67

23c. NAME OF CEMETERY OR CREMATORY: St. Joseph's

23d. LOCATION (City or Town) (County) (State): Bonneauville Adams Pa

24. FUNERAL DIRECTOR: H.F. Walter — ADDRESS: McSherrystown, Pa.

25a. REC'D BY REGISTRAR DATE: JUN 30 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08473 08468

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Sylvan Manor HEALTH Care Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON D C 47.3
d. STREET ADDRESS: 2615 Wisconsin Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MABEL Middle Lost SHEA
4. DATE OF DEATH: Month JUNE Day 13 Year 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/22/1887
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SECRETARY
10b. KIND OF BUSINESS OR INDUSTRY: RETIRED
11. BIRTHPLACE (County & State, or foreign country): Bellevue, Ohio
12. CITIZEN OF WHAT COUNTRY?: U.S.A
13. FATHER'S NAME: JAMES SHEA
14. MOTHER'S MAIDEN NAME: CATHERINE OBINS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ~ (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 578-01-3048
17. INFORMANT: MRS. A.T. WILLICK (SISTER) Address: WASH. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Basilar artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from May, 1965 to June 13, 1967, that (I) (we) last saw the deceased alive on June 13 1967 and that death occurred at 805 M, from causes and on the date stated above.

22a. SIGNATURE: Robert T. Thibadeau M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-13-67
22c. PHYSICIAN'S NAME (Type): ROBERT T. THIBADEAU
22d. ADDRESS: ROCKVILLE MD 20852

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6-15-67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): WASHINGTON D.C.

24. FUNERAL DIRECTOR: James E. DeVol ADDRESS: Wash. D. C.
25a. REC'D BY REGISTRAR DATE: JUN 23 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08474 08469

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Wash San & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 114 Hamilton Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Joseph Last: Shipley
4. DATE OF DEATH: Month: 6 Doy: 15 Year: 1967

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-7-03
9. AGE (In yeors last birthday) 63 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Sales Manager
10b. KIND OF BUSINESS OR INDUSTRY: Repair Automobile
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ruben Shipley
14. MOTHER'S MAIDEN NAME: Margaret Corby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Nox (If yes give wor or dotes of service) None
16. SOCIAL SECURITY NO.: 578-01-6632
17. INFORMANT: Mr. Russell Shipley Address: 5206 Blacksmake Hill Crest Heights, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Insufficiency Acute — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** thot I took chorge of the remoins described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, ond in my opinion death resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 6/15/67
EXAMINER'S NAME (Type) John G. Ball Address (Street, city, town, or county): 7936 Old Georgetown Rd. Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 19, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): Frederick, Maryland

24. FUNERAL DIRECTOR: John B. Thomas Warner E. Pumphrey, Inc. ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUN 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED BY MEDICAL EXAMINER - DR. ROGERS

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08475 08470

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1417 ~~Glenallen~~ Glenallen Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Alice	L.	Singer	June	21	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		4/22/04	63 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bookkeeper	Apartment House	District of Columbia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
French D. Bussey	Bessie B. Beattie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	579-48-9677	Jessie N. Seymour	1417 Glenallen Avenue Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory, cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH
4H3X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Cor pulmonale + Acidosis
DUE TO (c): Pulmonary Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 14, 1967, to June 21, 1967, that (I) (we) last saw the deceased alive on 6-20 1967, and that death occurred at 1 ½ M, from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☒ / MED. DIRECTOR ☐ / STAFF PHYS. ☐	22b. DATE SIGNED
Edward J. Richards M.D.		June 21, 1967

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Edward J. Richards	11011 Georgia Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	June 24, 1967	Cedar Hill Cemetery	Suitland, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Fairfax L. Smith Warner E. Pumphrey, Inc.	8434 Georgia Avenue Silver Spring, Md.	JUN 28 1967	J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08476 Item #9 Film #G369 6/14/67 pc & Item #1d 08471

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
   c. LENGTH OF STAY IN 1b: 2yrs
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 200 Rolling Road

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland b. COUNTY: Montg,
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
   d. STREET ADDRESS: 200 rolling Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Dessie Middle: Londa Last: Sisler

4. **DATE OF DEATH**: Month: June Day: 7th Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 23-1882

9. AGE (In years last birthday): 85 87 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Preston Co. W.Va

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Zachariah Smith

14. MOTHER'S MAIDEN NAME: Susan Wilhalm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: Paul A. Sisler. As No 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Minutes
4200
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): A. H. D. — Year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 19 65 to 6-7 19 67, that (I) (we) last saw the deceased alive on May 25 19 67, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Jack Hummerick M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-8-67

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-10-67

23c. NAME OF CEMETERY OR CREMATORY: Terra Alta

23d. LOCATION (City, town or county) (State): Terra Alta. W.Va

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ernest C. Gartner. Gaithersburg. Md.
Ernest C. Gartner

25a. DATE: JUN 12 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08477 08472

1. PLACE OF DEATH
a. CDUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11101 Slye Court

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. CDUNTY: Montgomery
c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 11101 Slye Court
e. IS RESIDENCE DN A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Esther Middle: Anna Last: Slye
4. DATE OF DEATH: Month: June Day: 20 Year: 1967
5. SEX: Female
6. COLDR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDDWED ☐ DIVDRCED ☐
8. DATE DF BIRTH: 9/24/1910
9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): State of Maryland
10b. KIND OF BUSINESS DR INDUSTRY: Employment Serv
11. BIRTHPLACE (County & State, or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Humpherson
14. MDTHER'S MAIDEN NAME: Anne Foster
15. WAS DECEASED EVER IN U.S. ARMED FDRCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SDCIAL SECURITY ND.:
17. INFDRMANT: Harry L. Slye Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of lung with metasteses. — INTERVAL BETWEEN DNSET AND DEATH: 19 months.
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TD (b): DUE TO (c):
PART II. DTHER SIGNIFICANT CDNDITIDNS CONTRIBUTING TD DEATH BUT NDT RELATED TD THE TERMINAL DISEASE CDNDITIDN GIVEN IN PART 1(a)
19. WAS AUTDPSY PERFDRMED? YES ☐ ND ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CDNTRIBUTING ☐ CAUSE DF DEATH (IF EITHER, NDTIFY MEDICAL EXAMINER)
20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME DF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY DCCURRED While at work ☐ Not While at work ☐
20e. PLACE DF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct, 1965 to 6/20, 1967, that (I) (we) last saw the deceased alive DN 6/20 19 67, and that death occurred at 1:14 M, from the causes and DN the date stated above.

22a. SIGNATURE: Richard H. Huffman, M.D. ATTENDING PHYS. ☒ MED. DIRECTDR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/21/67
22c. PHYSICIAN'S NAME (Type): RICHARD HUFFMAN
22d. ADDRESS: 2001 – EYE Street, N.W.

23a. BURIAL, CREMATION, REMDVAL (Specify): Burial
23b. DATE THEREDF: June 24/1967
23c. NAME OF CEMETERY DR CREMATDRY: Rock Creek
23d. LDCATIDN (City, town or county) (State): Washington D.C.

24. FUNERAL DIRECTDR: Arthur Waters ADDRESS: 254 Garfield St. N.W. Washington, D.C. 20012
25a. REC'D BY REGISTRAR DATE: JUN 26 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G389 6/15/67 pc

08478

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08473

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5901 7th Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Darwin — Middle Enoch — Last SMITH
4. DATE OF DEATH: Month June — Day 5 — Year 19 67
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 9, 1894
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Captain, U. S. Army
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pittsburg, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Samuel Smith
14. MOTHER'S MAIDEN NAME: Rosa Eaton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes
16. SOCIAL SECURITY NO.: 579-48-1324
17. INFORMANT: Washington, Address D. C.
Mrs. Ethel E. Smith, 5901 7th St., N. W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis, acute — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes
DUE TO (b): Coronary arteriosclerosis, severe — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY. Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): John G. Ball, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 6 June 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/8 Gillison
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City or Town) (County) (State): Arlington, Va.

24. FUNERAL DIRECTOR: John T. Rhines & Co. ADDRESS: 3015 12th Street, N.W., Washington, D. C.
25a. REGISTRAR DATE: JUN 12 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jordan

VR A15ME (5)
6M 1/67

Items 18-21 Film 390 6-26 6

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08473 08474

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural
c. LENGTH OF STAY IN 1b: 1/2 hr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Rockbridge
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lexington
d. STREET ADDRESS: Rt. #4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: George — Middle: Edward — Last: Smith

4. DATE OF DEATH: Month: June — Day: 11 — Year: 1967

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 23, 1943

9. AGE (In years last birthday): 23 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Textile

11. BIRTHPLACE (State or foreign country): Virginia - Rockbridge County

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Edward Davis

14. MOTHER'S MAIDEN NAME: Martha Elizabeth Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Asphyxia due to Drowning — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
DUE TO
(b):
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last. 929.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o): 20b. Went in swimming in river and drowned

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. 3:30 p.m. 6/11 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒ 2

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Potomac River

20f. (City or town) (County) (State): Montg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John S. Rogers M.D.
EXAMINER'S NAME (Type): John S. Rogers M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): 12 Seminary Rd. Silver Spg. Md.

22. DATE SIGNED: June 14, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-16-67
23c. NAME OF CEMETERY OR CREMATORY: New Monmouth
23d. LOCATION (City or Town) (County) (State): Rockbridge Co., Virginia

24. FUNERAL DIRECTOR: Harrison Fun'l. Home — ADDRESS: Lexington, Va.
W. H. Erickenberger, Vienna, Va.

25a. REC'D BY REGISTRAR DATE: JUN 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ME Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08480 08473

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 31 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Kensington Gardens Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington. 47-3
d. STREET ADDRESS: 5124 33rd St Wash. D.C.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Hugh — Middle: P. — Last: Smyth
4. DATE OF DEATH: Month: 6 — Doy: 1 — Year: 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-5-1883
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-Employed
10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed
11. BIRTHPLACE (County & State, or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick Smyth.
14. MOTHER'S MAIDEN NAME: Margaret Doyle.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dates of service)
16. SOCIAL SECURITY NO.: 574-60-1738
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 Minutes
DUE TO
Conditians, if any, which gave rise to immediote couse (a), stating the underlying cause last.
(b)
DUE TO
(c)
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emphysema.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): No
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): None
20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m.: None
20d. INJURY OCCURRED While at work ☑ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): None
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from June 1, 1966, to June 1, 1967, that (I) (~~we~~) last saw the deceased alive on May 31 1967, and that death occurred at 10 P. M, from causes and on the date stated above.

22a. SIGNATURE: James M. Hoffus M.D — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 1, 1967
22c. PHYSICIAN'S NAME (Type): James M. Hoffus M.D
22d. ADDRESS: 5415 - Connecticut Ave Wash-DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-5-1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
23d. LOCATION (City or Town) (County) (State): Wash. D.C.

24. FUNERAL DIRECTOR: Hanlon F. H. — ADDRESS: 474 Pa. Ave. N.W. Wash. DC.

25a. RECD. BY REGISTRAR DATE: JUN 6 1967
25b. REGISTRAR'S SIGNATURE: Josephine Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08481 — 09879

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington —
c. LENGTH OF STAY IN 1b: 2 Months - 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Kensington Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
b. COUNTY: 47-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Washington - D C.
d. STREET ADDRESS: 5124 - 33rd = Street NW.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mary	E.	Smyth.	June	29	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female.	White		March 28-1889	78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Washington. D.C	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Beaver.	Margaret Galvin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	579-60-1738	Mrs. MARGARET Boyer (Daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cancer of liver	Unknown
DUE TO (b)	Cancer of Colon	Unknown
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1538

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None	None

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
None		None	

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from June, 1966, to June 29, 1967, that (I) (we) last saw the deceased alive on June 30 1967, and that death occurred at 9:45 M, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
James M. Loftus		6/29/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
JAMES M. Loftus	5415 - Connecticut Ave. N.W. Wash. D.C.

23a. BURIAL ~~CREMATION~~ ~~REMOVAL~~ (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	7/1/1967	Mt. Olivet	Wash. D.C.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Hanlon Funeral Home - Wash. D.C.	JUL 12 1967	J. Charles Judge

2 1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08482 — 08476

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Kensington
   c. LENGTH OF STAY IN 1b: 24yrs 10mo. 16 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: D.C. — b. COUNTY: —
   c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town): Washington - D.C. 47.3
   d. STREET ADDRESS: 3800 - McCall St. N.W
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Rose — Middle: S. — Lost: Spingarn

4. **DATE OF DEATH**: Month: June — Day: 16 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 14, 1876
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (County & Stote, or foreign country): ROMANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick SACHTEK
14. MOTHER'S MAIDEN NAME: Wilhelmina (UNKNOWN)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service): NO
16. SOCIAL SECURITY NO.: 219-54-8440
17. **INFORMANT** Address: MRS. LUCIE BRATENAHL, WASH., D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): generalized arteriosclerosis C — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO (b): general debility
DUE TO (c):
Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse last.
4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): pemphigoid retn. C sec. Staphylococcal infection
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this hospital) attended the deceased from 8-19, 19 64 to 6-16, 19 67, that (I) (we) last saw the deceased alive on 6-15 19 67, and that death occurred at 1:45 P.M., from couses and on the date stated above.

22a. SIGNATURE: R. F. Sengstack M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 6-16-67
22c. PHYSICIAN'S NAME (Type): GEORGE F. SENGSTACK, M.D. — 22d. ADDRESS: 9241 COL. BLVD, SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION — 23b. DATE THEREOF: 6/17/67 — 23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREM. — 23d. LOCATION (City or Town) (County) (Stote): SUITLAND, MD.

24. FUNERAL DIRECTOR: Joseph Gawler Sons — ADDRESS: 5130 WISCONSIN AVE. Washington D.C. — 25a. REC'D BY REGISTRAR DATE: JUN 26 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

Items 18&21 Film 390
7-13-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08483 08477

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, on the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. S may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK c. LENGTH OF STAY IN 1b:	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MD b. COUNTY: Mont. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 15:1 d. STREET ADDRESS: Cherry Hill Rd e. IS RESIDENCE ON A FARM? YES ☒ NO ☒
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. San & Hospital	
3. NAME OF DECEASED (Type or print): First Robert Middle Zelefro Last Spry	4. DATE OF DEATH: Month June Day 17 Year 1967
5. SEX: M 6. COLOR OR RACE: W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH: Aug 7-22 9. AGE (In years last birthday): 44 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARM MANAGER 10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Md 12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Irving Spry	14. MOTHER'S MAIDEN NAME: Helen Craddock
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) W.W. II 16. SOCIAL SECURITY NO.: 214-18-4094	17. INFORMANT Address: mrs Naomi Spry - wife

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Coronary artery heart disease

DUE TO

(c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Leap M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): BELDEN R. LEAP M.D. Address (Street, city, town, or county): Rockville

22. DATE SIGNED: June 17, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF: June 20 1967	23c. NAME OF CEMETERY OR CREMATORY: Grace Episcopal	23d. LOCATION (City or Town) (County) (State): Bethesda Prince Geo Md.	
24. FUNERAL DIRECTOR: J. Arthur Waters	ADDRESS: 25th Gabriel Street N.W. Washington, D.C. 20012	25a. REC'D BY REGISTRAR DATE: JUN 21 1967	25b. REGISTRAR'S SIGNATURE: Charles Jones	

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08484 — 08478

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
   c. LENGTH OF STAY IN 1b: 5 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Suburban Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
   d. STREET ADDRESS: 2213 Shorefield Rd. Apt. 264
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: MAE — Middle: A. — Last: STEWART

4. **DATE OF DEATH**: Month: June — Day: 20 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/19/07

9. AGE (In years last birthday): 59 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State, or foreign country): York. Pa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Kauffman

14. MOTHER'S MAIDEN NAME: Jennie Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service):

16. SOCIAL SECURITY NO.: —

17. **INFORMANT**: Lawrence Stewart - Husband. Address: (same as above)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b) and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Hepatic failure
   DUE TO (b): Anemia after Mastectomy
   DUE TO (c): Carcinoma Stomach
   Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.
   1533
   INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6/10/67, 19__ to 6/20/67, 19__ that (I) (we) last saw the deceased alive on 6:20 AM 19__, and that death occurred at 6:20 PM, from causes and on the date stated above.

22a. SIGNATURE: Richard C. Myers — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/20/67

22c. PHYSICIAN'S NAME (Type): RICHARD C. MYERS

22d. ADDRESS: 8512 Old Georgetown Rd. Bethesda

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6-23-67

23c. NAME OF CEMETERY OR CREMATORY: PARKLAWN

23d. LOCATION (City or Town) (County) (State): Rockville Mo. MD

24. FUNERAL DIRECTOR: SALAMONE FUNERAL HOME — ADDRESS: FREDERICK, MD

25a. REC'D BY REGISTRAR DATE: JUN 26 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08485

CERTIFICATE OF DEATH

08479

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
   c. LENGTH OF STAY IN 1b: 13 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Wisconsin — b. COUNTY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Madison
   d. STREET ADDRESS: 1921 Northwestern
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Gordon — Middle: Wayne — Last: STOFLET

4. **DATE OF DEATH**: Month: June — Day: 29 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 18, 1946

9. AGE (In years last birthday): 20 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USMC

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Madison, Wisconsin

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gordon Stoflet

14. MOTHER'S MAIDEN NAME: Virginia Ginger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: UNKNOWN

17. **INFORMANT** Address: Hospital records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Severe Craniocerebral injury due to missile
DUE TO: Severe craniocerebral injury due to missile
996X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 6 wks. 6 wks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Enemy Action

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: May 13 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State): Viet Nam

21. **I certify** that (I) (this hospital) attended the deceased from June 16, 1967, to June 29, 1967, that (I) (we) last saw the deceased alive an June 29 1967, and that death occurred at 205A M, from causes and on the date stated above.

22a. SIGNATURE: Fredrick L Edelman — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 6/30/67

22c. PHYSICIAN'S NAME (Type): F. L. EDELMAN, M. D.

22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-1-1967

23c. NAME OF CEMETERY OR CREMATORY: Roselawn Memorial Park Cemetery

23d. LOCATION (City or Town) (County) (State): Madison Wisconsin

24. FUNERAL DIRECTOR: W. W. Chambers Co. ADDRESS: 1400 Chapin Street, N. W. Washington, D.C.

25a. REC'D BY REGISTRAR DATE: JUL 3 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08486

CERTIFICATE OF DEATH

08480

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood 16.2
d. STREET ADDRESS: 3800 Shephard Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Leroy — Last: Stoner Sr
4. DATE OF DEATH: Month: June — Doy: 13 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/26/95
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Maurice Stoner
14. MOTHER'S MAIDEN NAME: Reynolds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): W.W. I (Army)
16. SOCIAL SECURITY NO.: 216-44-8849
17. INFORMANT — Address: Hospital Records, Wash. San. & Hosp.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Metastatic Carcinoma of bladder
DUE TO (c): Carcinoma of bladder
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 1810
INTERVAL BETWEEN ONSET AND DEATH: 6 Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March, 1964, to 6/13, 1967, that (I) (we) last saw the deceased alive on 6/12 1967, and that death occurred at 10 AM, from causes and on the date stated above.

22a. SIGNATURE: Arthur J. Wilets — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/13/67
22c. PHYSICIAN'S NAME (Type): Arthur J. Wilets
22d. ADDRESS: 1015 Spring st Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 16, 1967
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Colmar Manor Pro Geo Md.

24. FUNERAL DIRECTOR — ADDRESS: F. Gasch's Sons Hyattsville, Md.
25a. REC'D BY REGISTRAR: JUN 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08487 — 08481

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 10700 Swain Lock Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT LEE Middle Last SWAIN, Sr.

4. DATE OF DEATH: Month June Day 3 Year 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept.20,1905
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jessie A. Swain
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-07-0028
17. INFORMANT: Virginia M. Swain-Item# 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b): Coronary atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19 63 to 6-3, 1967, that (I) (we) last saw the deceased alive on 6-3 1967, and that death occurred at 4:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: Donald K Bucy — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/3/67
22c. PHYSICIAN'S NAME (Type): D. L. Bucy
22d. ADDRESS: 809 Viers Mill Rd., Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/6/67
23c. NAME OF CEMETERY OR CREMATORY: Monocacy
23d. LOCATION (City or Town) (County) (State): Beallsville, Md.

24. FUNERAL DIRECTOR ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.
25a. REC'D BY REGISTRAR DATE: JUN 8 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08488 08432

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 1 ½ mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): University Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Hyattsville
d. STREET ADDRESS: 1914 Fox St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Eva Middle Belle Last Sweeney
4. DATE OF DEATH: Month 6 Day 6 Year 1967
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8/29/~~1891~~ 1890
9. AGE (In years last birthday): 76~~78~~ yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Government clerk
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (County & State, or foreign country): Alexandria, Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Marmaduke
14. MOTHER'S MAIDEN NAME: Alice Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 217-52-6495
17. INFORMANT: George W. Sweeney — Address: 1914 Fox Street Hyattsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Renal Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular Dis
DUE TO (c):
4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 1967, to June, 1967, that (I) (we) last saw the deceased alive on June 6 1967, and that death occurred at 2:20 PM, from the causes and on the date stated above.

22a. SIGNATURE: Bernard A Fitzgerald M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-6-67
22c. PHYSICIAN'S NAME (Type): Bernard Fitzgerald, MD
22d. ADDRESS: 217 University Blvd., E., S. S., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 9, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d. LOCATION (City, town or county) (State): Alexandria, Virginia

24. FUNERAL DIRECTOR: John B. Thomas Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUN 12 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08483 08483

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SILVER SPRINGS
c. LENGTH OF STAY IN 1b: MOST OF LIFETIME
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): HOLY CROSS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SILVER SPRINGS.
d. STREET ADDRESS: 2417 - EVANS DRIVE ~~FOREST GLEN RD.~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHERINE Middle C Last TALBERT
4. DATE OF DEATH: Month 6 Day 9 Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-4-88
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: - - -
11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FREDERICK - MUNCHMEYER
14. MOTHER'S MAIDEN NAME: FRANCES. - STEVENSSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service): - -
16. SOCIAL SECURITY NO.: 579-48-3906
17. INFORMANT: JANICE HEDDA Address: 2417 EVANS DR. SILVER SPRINGS. MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 4231 CONSTANT

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): GANGRENE OF RT LEG - AMPUTATED
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 22, 1967 to June 9, 1967, that (I) (we) last saw the deceased alive on June 9 1967, and that death occurred at 9 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W F Marcus M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/10/67
22c. PHYSICIAN'S NAME (Type): WILLIAM MARCUS.
22d. ADDRESS: 10620 GA. AVE. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 6-14-1967
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City, town or county) (State): Suitland, Md.

24. FUNERAL DIRECTOR: Joseph Gawler's Sons ADDRESS: 5730 WISC AVE WASH DC
25a. REC'D BY REGISTRAR DATE: JUN 20 1967
25b. REGISTRAR'S SIGNATURE: J Charles Juggs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

13 1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08480

CERTIFICATE OF DEATH

08484

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring	c. LENGTH OF STAY IN 1b: D.O.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Holy Cross Hospital	d. STREET ADDRESS: 5001 Russett Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒	
3. NAME OF DECEASED (Type or print): First: William Middle: Irving Lost: Taylor, Jr.	4. DATE OF DEATH: Month: June Day: 20 Year: 1967
5. SEX: male	6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: June 20, 1926
9. AGE (In years last birthday): 41 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Comptroller Accountant	10b. KIND OF BUSINESS OR INDUSTRY: School Sidwell Friends
11. BIRTHPLACE (County & State, or foreign country): New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Irving Taylor	14. MOTHER'S MAIDEN NAME: Eleanor Sullivan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes WWII & Korean	16. SOCIAL SECURITY NO.: Yes 133-16-5653
17. INFORMANT: Josephine R. Taylor	Address: 5001 Russett Road Rockville, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Metastatic Carcinoma of lungs — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO (b):

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Feb, 1967 to 6/17, 1967, that (I) (we) last saw the deceased alive on 6/17 1967, and that death occurred at 9:55 M, from causes and on the date stated above.

22a. SIGNATURE: Sonia K. Alpert M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐		22b. DATE SIGNED: 6-21-67
22c. PHYSICIAN'S NAME (Type): Louis K. Alpert, MD	22d. ADDRESS: 2300 K St. N.W.	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: June 23, 1967	23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery	23d. LOCATION (City or Town) (County) (State): Arlington, Virginia	
24. FUNERAL DIRECTOR: John B. Thomas Warner E. Pumphrey, Inc.	ADDRESS: 8434 Georgia Avenue Silver Spring, Md.	25a. REC'D BY REGISTRAR DATE: JUN 26 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08492 (M) 08486

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 20 M 1/66

1. PLACE OF DEATH
   a. COUNTY: Montgomery MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
   c. LENGTH OF STAY IN 1b: years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 5515 Johnson Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 15.1
   d. STREET ADDRESS: 5515 Johnson Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VIRGINIA Middle B. Lost THAMES

4. DATE OF DEATH: Month June Day 13th Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 5, 1899
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Powhatan Bouldin
14. MOTHER'S MAIDEN NAME: Mary E. Moir

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Neice, Mrs. W.G.Clayton, Address: 2912 N.St., N.W. Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201
IMMEDIATE CAUSE (a): Acute coronary failure
DUE TO
(b): Myocarditis of unknown etiology
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Nov. 14, 1939 to June 13, 1967, that (I) (~~we~~) last saw the deceased alive on June 8th 1967, and that death occurred at 4:44 P.M. from causes and on the date stated above.

22a. SIGNATURE: W. LeRoy Dunn M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-13-67
22c. PHYSICIAN'S NAME (Type): W. LeRoy Dunn
22d. ADDRESS: 5508 Park Road Chevy Chase, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-16-67
23c. NAME OF CEMETERY OR CREMATORY: Arlington Natl Cem.
23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: JUN 22 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2a,b,c & d Film #G390 7/10/67 pc

08493

CERTIFICATE OF DEATH

08487

1. PLACE OF OEATH
o. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Suburban Hospital

2. USUAL RESIOENCE (Where deceosed lived, if institution: Residence before odmission)
o. STATE: Maryland Texas — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Rockville/ Austin — 80.3
d. STREET ADDRESS: 421 Brady Lane Potomac Valley Nursing Home
e. IS RESIOENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howard — Middle: R. — Lost: Thomas
4. OATE OF OEATH: Month: June — Doy: 30, — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: W.
7. MARRIEO ☐ NEVER MARRIEO ☐ WIDOWED ☒ OIVORCED ☐
8. DATE OF BIRTH: July 12, 1887
9. AGE (In yeors lost birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Oays — IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KINO OF BUSINESS OR INOUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John B. Thomas
14. MOTHER'S MAIDEN NAME: Frances Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: 263-62-0653-T
17. INFORMANT: J. L. Thomas- Rockville, Md. — Address: 13900 Glen Mill Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Cerebrovascular thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
332X
DUE TO (b):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART 1(o): Cholecystitis and cholelithiasis
19. WAS AUTOPSY PERFORMEO? YES ☒ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. OESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify thot (I) (this hospital) attended the deceased from 10, 1965, to 6-30 1967, that (I) (we) lost sow the deceased alive on 6-29 1967, ond that death occurred at ____ M, from causes and on the dote stoted above.

22o. SIGNATURE: S. Jones/DK Bucy M.O. — ATTENDING PHYS. ☒ MED. OIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-30-67
22c. PHYSICIAN'S NAME (Type): Stephen N. Jones
22d. ADDRESS: 889 Vens Mill Rd Rockville Md

23o. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. OATE THEREOF: 7/1/67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City or Town) (County) (Stote): Prince George Co., Maryland

24. FUNERAL DIRECTOR ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.
25o. REC'D BY REGISTRAR OATE: JUL 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08494 08483

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): University Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Wheaton Silver Spring 15,1
d. STREET ADDRESS: 1132 Arcola ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Middle Frances Last Thompson

4. DATE OF DEATH: Month June Day 19 Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/4/1878
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Barnes
14. MOTHER'S MAIDEN NAME: Margaret Coupard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Dorsey L. Thompson Address: 1132 Arcola Avenue Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Disease, Cong. Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.
DUE TO (b): asthd. — seven yrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): General Debility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 1967, to June 19, 1967, that (I) (we) last saw the deceased alive on June 18 1967, and that death occurred at 3:12 M, from causes and on the date stated above.

22a. SIGNATURE: R.C. Bufalino M.D.
M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 19, 1967
22c. PHYSICIAN'S NAME (Type): R. C. BUFALINO, M.D.
22d. ADDRESS: 1429 University Blvd. W. Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 22, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery
23d. LOCATION (City or Town) (County) (State): Forest Glen, Maryland

24. FUNERAL DIRECTOR: C. Glen Carter (Glen Carter) Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUN 22 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08495

CERTIFICATE OF DEATH

08489

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN this place: 1mo 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens San.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West River
d. STREET ADDRESS: Shady Oaks Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Arthur — Middle: G — Last: Tool Sr.

4. **DATE OF DEATH**: Month: June — Day: 4 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 5, 1877
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Scientist
11. BIRTHPLACE (County & State or foreign country): Jasper Co. Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Tool
14. MOTHER'S MAIDEN NAME: Salina E Oldham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 220-44-1310
17. **INFORMANT** Address: Mr. Arthur Tool Jr. (same as #2)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — Acute Cong. Failure
DUE TO (b): Infection
DUE TO (c): Acute.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
H221

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Recent Surgery Removal leg because of gangrene

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Mar., 19 67 to June, 196 7, that (I) (we) last saw the deceased alive on June 3 1967, and that death occurred at 4:50 P.M., from causes and on the date stated above.

22a. SIGNATURE: R. C. Bufalino
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-4-67
22c. PHYSICIAN'S NAME (Type): Russell C. Bufalino, M.D.
22d. ADDRESS: 1429 University Blvd W. Sil. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 9. 1967
23c. NAME OF CEMETERY OR CREMATORY: Monroe Cemetery
23d. LOCATION (City or Town) (County) (State): Fairview Twnshp. Jasper Co. Iowa

24. FUNERAL DIRECTOR — ADDRESS: J. Arthur Walters, 254 Carroll St NW. Wash DC
25a. REC'D BY REGISTRAR DATE: JUN 6 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08496 08490

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3½ hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. & Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7115 Woodland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Lee — Last: Towne
4. DATE OF DEATH: Month: June — Day: 16 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/21/06
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Proff Printer Reader
10b. KIND OF BUSINESS OR INDUSTRY: G.P.O. U.S. Govt.
11. BIRTHPLACE (County & State, or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William E. Towne
14. MOTHER'S MAIDEN NAME: Pearl Reese
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 067-01-1899
17. INFORMANT: Pearl E. Towne — Address: 7115 Woodland Avenue Takoma Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO (b): Severe arteriosclerotic heart disease — years
DUE TO (c): With acute coronary insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 19 65, to June 16, 1967, that (I) (we) last saw the deceased alive on June 16 1967, and that death occurred at 6 45 p. M, from causes and on the date stated above.

22a. SIGNATURE: Albert H. Grollman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/16/67
22c. PHYSICIAN'S NAME (Type): ALBERT H. GROLLMAN
22d. ADDRESS: 1106 SPRING ST. SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 20, 1967
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Prince Georges Co., Md.
24. FUNERAL DIRECTOR: Glen Carter, Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUN 21 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

CLEARED BY MEDICAL EXAMINER

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08497 — **CERTIFICATE OF DEATH** — 08491

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 6 hrs 5 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress): Naval Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: North Carolina — b. COUNTY
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Camp LeJeune
d. STREET ADDRESS: MOQ 2509
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Doy	Year
Christopher	Thomas	TOWNSEND	June	27	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In yeors last birthday) yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc	NEVER MARRIED ☒	16 March 1967		3			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
N/A	N/A	Camp LeJeune, N. C.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas A. Townsend	Anne Taubitz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
N/A	N/A	N/A	Thomas A. Townsend, MOQ 2509, Camp LeJeune N.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Congenital Heart Disease, Cyanotic — INTERVAL BETWEEN ONSET AND DEATH
7545
DUE TO
Conditions, if any, which gove rise to immediate couse (o), stoting the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) ottended the deceosed from June 26, 1967, to June 27, 1967, that (I) (we) last saw the deceosed alive on June 27 1967, and that deoth occurred ot 505A M, from couses ond on the dote stoted above.

22a. SIGNATURE: R Tompkins LCDR/USN — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: June 27, 1967

22c. PHYSICIAN'S NAME (Type): LCDR A. E. TOMPKINS, LCDR MC USN — 22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6-29-67	Arlington National	Arlington, Virginia

24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N.W., Washington, D.C.

25a. REC'D BY REGISTRAR DATE JUN 29 1967

25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08498

CERTIFICATE OF DEATH

08492

1

Cleared with Coroner R.B.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Stote Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Washington San. and Hsp.

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: Md. — b. COUNTY: P.G. Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): Takoma Park
d. STREET ADDRESS: 7802 Wildwood Dr.
e. IS RESIOENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Otis — Middle: Carroll — Lost: Trimble
4. DATE OF DEATH: Month: 6 — Doy: 5 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: Wht
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-17-96
9. AGE (In yeors last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Exchange officer
10b. KINO OF BUSINESS OR INDUSTRY: State Dept.
11. BIRTHPLACE (County & Stote, or foreign country): Arkansas
12. CITIZEN OF WHAT COUNTRY?: U S.A.

13. FATHER'S NAME: Mathew ~~Allen~~ Trimble
14. MOTHER'S MAIDEN NAME: Annie McFarland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give wor or dotes of service): WW1
16. SOCIAL SECURITY NO.: 578-32-0090
17. INFORMANT: Eva Trimble — Address: 7802 Wildwood Drive
Hospital Records — Takoma Park, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): arteriosclerotic Heart Disease — 3-4 mos.
DUE TO (c):
Conditions, if ony, which gove rise to immediote couse (o). stoting the underlying couse last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (~~this hospital~~) attended the deceased from April 20, 1967, to June 5, 1967, that (I) (~~we~~) last saw the deceased alive an June 2, 1967, and that death accurred at 11:35 p.m. from causes and an the date stated abave.

22a. SIGNATURE: Russell B. Arnold M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: June 5, 1967
22c. PHYSICIAN'S NAME (Type): Russell B. Arnold M.D.
22d. ADDRESS: 1106 Spring Street, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Trans-burial
23b. DATE THEREOF: June 9, 1967
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City or Town) (County) (Stote): Green Forest, Arkansas

24. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue, Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: JUN 12 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08493

CERTIFICATE OF DEATH

08493

1 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Monte.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville, 15.1
d. STREET ADDRESS: 1214 Gladstone Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

90

3. NAME OF DECEASED (Type or print): First: Luther — Middle: A. — Last: Trunnell
4. DATE OF DEATH: Month, Day, Year: June 7, 1967 19

5. SEX: male ~~white~~
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 29, 1887
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John A. Trunnell
14. MOTHER'S MAIDEN NAME: Roberta Alexander

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 577-16-4972
17. INFORMANT — Address: Agnes C. Trunnell-Item # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Cerebral Arteriosclerosis — 2 years.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma Prostate.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from May 12, 1965, to June 7, 1967, thot (I) (~~not~~) last saw the deceased alive on June 6 1967, and that death occurred at 5:30 AM from couses and on the dote stoted above.

22a. SIGNATURE: J. Blaine Fitzgerald M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/7/67.
22c. PHYSICIAN'S NAME (Type): J. Blaine Fitzgerald
22d. ADDRESS: 8218 Wis. Ave., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/9/67
23c. NAME OF CEMETERY OR CREMATORY: Rockville
23d. LOCATION (City or Town) (County) (State): Rockville, Md.

24. FUNERAL DIRECTOR — ADDRESS: Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.
25a. REC'D BY REGISTRAR — DATE: JUN 8 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08500 — 08494

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mill Creek Towne
c. LENGTH OF STAY IN 1b: 6 Mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 17801 Vineyard Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mill Creek Towne, Derwood
d. STREET ADDRESS: 17801 Vineyard Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rudolph — Middle: J — Last: Turco
4. DATE OF DEATH: Month: June — Day: 13 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 17, 1910
9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Section Chief -GPO
10b. KIND OF BUSINESS OR INDUSTRY: Printing Gov.
11. BIRTHPLACE (State or foreign country): Washington D.C
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Louis. Turco –
14. MOTHER'S MAIDEN NAME: Camilla DePaola

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes — WWII
16. SOCIAL SECURITY NO.: 577-40-0965
17. INFORMANT: Wife — Address: Bessie F. Turco — Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardialinfarction, coronary thrombosis, coronary arteriosclerosis.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 4 hr. / years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G. Ball M.D.
EXAMINER'S NAME (Type): JOHN G. BALL
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 6/14/67
Address (Street, city, town, or county): Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-17-67
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d. LOCATION (City or Town) (County) (State): Silver Spring, Maryland

24. FUNERAL DIRECTOR: ROBERT A. PUMPHREY, ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR: JUN 16 1967
25b. REGISTRAR'S SIGNATURE: Charles Gray

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08501 08495

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give neorest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Resmor Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 9704 Bexhill Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALEXANDER Middle Frank Last VAN ROSSUM
4. DATE OF DEATH: Month June Day 11, Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr. 15, 1877
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Belgium
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 082-05-8664
17. INFORMANT: Wife Address: 605-W. 113th St.
Jessie R. Van Rossum NYC, N. Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CIRCULATORY COLLAPSE — INTERVAL BETWEEN ONSET AND DEATH: MINS.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): A. S. H. D. — 5 YRS
DUE TO
(c): generalized arteriosclerosis — 10 YRS
4200
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): PNEUMONIA
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY, 1967, to 6/11, 1967, that (I) (we) last saw the deceased alive on 6/9 1967, and that death occurred at 1150 M, from causes and on the date stated above.

22a. SIGNATURE: Charles Saverese M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-12-67
22c. PHYSICIAN'S NAME (Type): CHARLES SAVERESE
22d. ADDRESS: 11125 Rockville, Pike Rockville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 6-15-67
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City or Town) (County) (State): Suitland, Maryland
24. FUNERAL DIRECTOR ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: JUN 16 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08502

CERTIFICATE OF DEATH

08496

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
   c. LENGTH OF STAY IN 1b: 21 min.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince George
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
   d. STREET ADDRESS: 3926 Suitland Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Baby Boy "A" — Middle: — Last: WADDELL

4. **DATE OF DEATH**: Month: June — Doy: 1 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 1, 1967

9. AGE (In years lost birthday) yrs.

IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min. 21

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (County & State, or foreign country): Bethesda, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Roger L. Waddell

14. MOTHER'S MAIDEN NAME: Cheryl Crider

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): N/A (If yes give wor or dotes of service): N/A

16. SOCIAL SECURITY NO.: N/A

17. **INFORMANT**: Suitland, Maryland — Address: Roger L. Waddell, 3926 Suitland Road

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity; Atelectasis, lung
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gove rise to immediote couse (a), stoting the underlying couse lost.
7635

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** thot ☒ (this hospital) ottended the deceased from June 1, 19 67 to June 1, 19 67, that ☒ (we) last saw the deceased olive on June 1 19 67, and thot deoth occurred at 755 P M, from couses ond on the date stated above.

22a. SIGNATURE: Jack E Winker — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: June 7, 1967

22c. PHYSICIAN'S NAME (Type): J. E. WINKER, M. D.

22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Transfer

23b. DATE THEREOF: 2 June 1967

23c. NAME OF CEMETERY OR CREMATORY: Naval Medical School

23d. LOCATION (City or Town) (County) (State): NNMC Bethesda, Md.

24. FUNERAL DIRECTOR — ADDRESS

25a. REC'D BY REGISTRAR DATE: JUN 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

7-268218

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08503

CERTIFICATE OF DEATH

08497

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 4 hrs 38 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
d. STREET ADDRESS: 3926 Suitland Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Boy "B" Middle: Lost: Waddell

4. DATE OF DEATH: Month: June Day: 2 Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 1, 1967

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: Days: 4 Hours: 38 Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Bethesda, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Roger L. Waddell

14. MOTHER'S MAIDEN NAME: Cheryl Crider

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): no

16. SOCIAL SECURITY NO.: N/A

17. INFORMANT: CPL Roger L. Waddell, USMC, 3926 Suitland Road, Suitland Md. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Prematurity, 700 grams; Atelectasis (lungs) — INTERVAL BETWEEN ONSET AND DEATH
762.5
DUE TO
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. I certify that (I) (this hospital) attended the deceased from June 1, 1967, to June 2, 19 67 that (I) (we) last saw the deceased olive an June 2 19 67, and that death accurred at 1215 p.m., from causes and on the date stated above.

22o. SIGNATURE: Ronald F. Swanger M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 7 June 1967

22c. PHYSICIAN'S NAME (Type): Ronald F. Swanger, M. D.

22d. ADDRESS: Naval Hospital, Bethesda, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify): Transfer

23b. DATE THEREOF: 2 June 1967

23c. NAME OF CEMETERY OR CREMATORY: Naval Medical School

23d. LOCATION (City or Town) (County) (Stote): NNMC, Bethesda, Md.

24. FUNERAL DIRECTOR ADDRESS

25o. REC'D BY REGISTRAR DATE JUN 12 1967

25b. REGISTRAR'S SIGNATURE: Charles Judgkins

7-268216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08504 08493

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): POTOMAC VALLEY NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTG.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CABIN JOHNS, MD
d. STREET ADDRESS: 8120 SEVEN LOCKS RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RAVA; Middle:; Last: WARE

4. DATE OF DEATH: Month: JUNE; Day: 24; Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: APR. 10, 1900

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. LABORER

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN HENRY WARE

14. MOTHER'S MAIDEN NAME: ESTELLA JACKSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Chronic pulmonary emphysema — 10 yrs.
DUE TO
(c): Asthmatic Bronchitis — 20 yrs +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19:

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that (I) (this hospital) attended the deceased from 5/1/67, 19___, to 6/24/67, 19___, that (I) (we) last saw the deceased alive an 6/18/67, 19___, and that death occurred at 2:00 M, from causes and an the date stated abave.

22a. SIGNATURE: Henry C. Scruggs M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/25/67

22c. PHYSICIAN'S NAME (Type): 5413 Cedar Lane Bethesda MD.

22d. ADDRESS: HENRY C. SCRUGGS M.D.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6/29/67

23c. NAME OF CEMETERY OR CREMATORY: FISHERMAN, S CEM.

23d. LOCATION (City or Town) (County) (State): ROCKVILLE, MD.

24. FUNERAL DIRECTOR: Robert L. Snowden

ADDRESS: ROBERT L. SNOWDEN ROCKVILLE, MD.

25a. REC'D BY REGISTRAR DATE JUL 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G390 6/28/67 pc

08505

CERTIFICATE OF DEATH

Items 14,23b,c,&d-FilmG390-7/18/67mnb

08499

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda(rural)
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Indiana
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Valparaiso
d. STREET ADDRESS: Rt.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Louise — Middle: Allen — Last: Warren

4. DATE OF DEATH: Month: June — Day: 9 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 29,1904

9. AGE (In years last birthday): 62 63 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): conee,Ill.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ben P. Allen

14. MOTHER'S MAIDEN NAME: Mary Louise March (Louisa)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 304 40 6832

17. INFORMANT: Seral Warren — Address: Rt.1 Valparaiso,Ind. 46383

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA OF THE BREAST — INTERVAL BETWEEN ONSET AND DEATH
170X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jun.9, 19 67, to Jun. 9, 19 67 that (I) (we) last saw the deceased alive on Jun.9 1967, and that death occurred at 7:00PM, from causes and on the date stated above.

22a. SIGNATURE: William R. Hix — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 11 June 1967

22c. PHYSICIAN'S NAME (Type): William R.Hix MD

22d. ADDRESS: Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/14/67

23c. NAME OF CEMETERY OR CREMATORY: LaCrosse Cemetery

23d. LOCATION (City or Town) (County) (State): LaCrosse, Ind. LaCrosse, Ind.

24. FUNERAL DIRECTOR: R.A.Pumphrey Funeral Home — ADDRESS: 7557 Wisc.Ave Bethesda,Md.

25a. REC'D BY REGISTRAR DATE: JUN 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1 2

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08506 Item #8 Film #G389 6/16/67 pc

CERTIFICATE OF DEATH

08500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 17 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Montgomery General Hospt.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring
d. STREET ADDRESS: 18471 Brooke Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MINERVA Middle NMN Lost WASHINGTON

4. DATE OF DEATH: Month 6 Doy 6 Year 1967

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6/19/93
9. AGE (In years lost birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: unemployed
11. BIRTHPLACE (County & Stote, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joshua Selby
14. MOTHER'S MAIDEN NAME: Christianna Budd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): no
16. SOCIAL SECURITY NO.: 578-26-5303
17. INFORMANT Address: Medical Records of Montg. General Hospt.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO (b): Arteriosclerosis — years.
DUE TO (c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this hospital) attended the deceased from 1965, 19__, to 6/6/67, 19__, that (I) (we) last saw the deceased alive an 6/6 1967, and that death occurred at 6:40 M, from causes and on the date stated above.

22o. SIGNATURE: Richard A. Yates M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/8/67
22c. PHYSICIAN'S NAME (Type): Dr. Richard Yates
22d. ADDRESS: Olney, Md. 20832

23o. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6/12/67
23c. NAME OF CEMETERY OR CREMATORY: SHARP STREET CEMETERY
23d. LOCATION (City or Town) (County) (Stote): SANDY SPRING, MONTG. MD.

24. FUNERAL DIRECTOR: George R. Brenda Rockville
ADDRESS
25a. RECD BY REGISTRAR DATE: JUN 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Yingling

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08507 08501

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress): Wash. San + Hosp.

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: Maryland
b. COUNTY: P.G.
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Greenbelt, md.
d. STREET ADDRESS: 22A Hillside Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Bertrand — Middle: Angus — Lost: Wells
4. DATE OF DEATH: Month: 6 — Doy: 13 — Year: 1967
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-15-1899
9. AGE (In yeors lost birthdoy): 67 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laundrey
10b. KIND OF BUSINESS OR INDUSTRY: Supt. Laundry
11. BIRTHPLACE (County & Stote, or foreign country): Danville Va
12. CITIZEN OF WHAT COUNTRY? U S
13. FATHER'S NAME: Charles Wells
14. MOTHER'S MAIDEN NAME: Ida -
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 216-09-0762
17. INFORMANT: Wife — Address: Mrs Esther L. Wells (same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(b):
DUE TO
(c): Atherosclerotic Heart Disease — 2-3 yrs.
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o): FREQUENT PREMATURE CONTRACTIONS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from MAY, 1962, to JUNE 13, 1967, that (I) ~~(we)~~ last saw the deceased alive an JUNE 13 1967, and that death accurred at ____ M, fram causes and an the date stated abave.

22a. SIGNATURE: Robert B. Irey M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-13-67
22c. PHYSICIAN'S NAME (Type): ROBERT B. IREY
22d. ADDRESS: 11161 New Hampshire Ave, Silver Spring

23o. BURIAL, CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: June 16. 1967
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State): Colmar Manor. Md.
24. FUNERAL DIRECTOR: Gardiner Walters — ADDRESS: 254 Canal St NW. Wash. DC
25a. REC'D BY REGISTRAR DATE: JUN 15 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jyaza

1 124

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08508

CERTIFICATE OF DEATH

08502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2hrs 40min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 8940 Jones Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marion — Middle: Leigh — Last: WELLS

4. DATE OF DEATH: Month: June — Day: 3 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6 Aug 1884

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gentlewoman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Sidney, Australia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Sir Hugh Dixon

14. MOTHER'S MAIDEN NAME: Emma Elizabeth Shaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220-44-2607

17. INFORMANT (Attorney): Andrew T. Altmann, Colorado Building, Address: Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO: subintimal hemorrhage, right coronary artery
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of liver
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 1:50AM 3 June 1967, to 4:30 AM 3 June 1967 that ☒ (we) last saw the deceased alive on 3 June 1967, and that death occurred at 4:30A M, from causes and on the date stated above.

22a. SIGNATURE: J. E. Goss LCDR, MC, USNR — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 3 June 1967

22c. PHYSICIAN'S NAME (Type): J. E. GOSS, LCDR MC USNR

22d. ADDRESS: Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6-7-67

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

23d. LOCATION (City or Town) (County) (State): Arlington, Virginia

24. FUNERAL DIRECTOR: Gawler Funeral Home, ADDRESS: 5130 Wisconsin Ave., N.W., Washington, D.C.

25a. REC'D BY REGISTRAR DATE: JUN 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08503 08503

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Holy Cross Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12628 Layhill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Joseph Middle M. Last Werek
4. DATE OF DEATH: Month 6 Day 23 Year 1967

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/10/81
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardner
10b. KIND OF BUSINESS OR INDUSTRY: self employed
11. BIRTHPLACE (County & State, or foreign country): France
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Michael werck
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 220-50 7362
17. INFORMANT: Josephine Wexler Address: College Park Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastrointestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
DUE TO (b): Duodenal Ulcer — 1 Mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): UREMIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Manth, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/8/67 19 to 6/23/67 19, that (I) (we) last saw the deceased alive on 6/23/67 19, and thot death occurred at 7:40 P.M., from causes and on the date stated abave.

22a. SIGNATURE: Henry C. Scruggs M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/23/67
22c. PHYSICIAN'S NAME (Type): HENRY C. SCRUGGS
22d. ADDRESS: 5413 Cedarlane Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 27, 1967
23c. NAME OF CEMETERY OR CREMATORY: Prospect Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Washington D. C.

24. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: JUN 28 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08510

CERTIFICATE OF DEATH

08504

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress): 99 Holy Cross Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Hyattsville 16 2
d. STREET ADDRESS: 6903 20th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Claude — Middle: W. — Last: Wessells

4. **DATE OF DEATH**: Month: June — Day: 22 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 28, 1902

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst. Supt.

10b. KIND OF BUSINESS OR INDUSTRY: PEPCO

11. BIRTHPLACE (County & Stote, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Walter Wessells

14. MOTHER'S MAIDEN NAME: Mary Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): no

16. SOCIAL SECURITY NO.: 577-09-3011

17. **INFORMANT**: Jessie A. Wessells-6903 20th Ave. Hyattsville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Brain Metastases. — INTERVAL BETWEEN ONSET AND DEATH: 2 Hours.
DUE TO
(b): Primary lung Carcinoma with metastases — 1-2 YEARS.
DUE TO
(c):

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.

1621

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from October, 19 65, to June 22, 19 67, that (I) (we) last saw the deceased alive an June 20 19 67, and that death accurred at 5:08 P M, from causes and on the date stated abave.

22a. SIGNATURE: Hugo G. Graziani, M.D. per Dr. Stephen Jones — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/22/67

22c. PHYSICIAN'S NAME (Type): Hugo G. Graziani, M.D.

22d. ADDRESS: 10101 Georgia Ave S.S. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 6/26/67

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION (City or Town) (County) (Stote): Prince Georges Co. Md.

24. FUNERAL DIRECTOR: The S H Nevins Co — ADDRESS: Washington, DC 2901-14th NW

25a. REC'D BY REGISTRAR DATE: JUN 23 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

Walter W. Wessells

Mary Nelson

no

577-09-3011 Jessie A. Wessells-6903 20th Ave.
Hyattsville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #13 Film #G390 7/6/67 pc

08511

CERTIFICATE OF DEATH

08505

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Montgomery	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Bethesda c. LENGTH OF STAY IN 1b: 20 Days	c. CITY OR TOWN (If outside corparate limits, write RURAL and give neorest town): Hyattsville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda, Maryland	d. STREET ADDRESS: 1514 Madison Street e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Maggie Middle: Mae Last: Wheeless	4. DATE OF DEATH: Month: June Day: 11 Year: 19 67
5. SEX: Female 6. COLOR OR RACE: White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 12 August 1917 9. AGE (In years last birthday): 49 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone Operator 10b. KIND OF BUSINESS OR INDUSTRY: Telephone Co.	11. BIRTHPLACE (County & State, or foreign country): Georgia 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charlton Carriton Spells	14. MOTHER'S MAIDEN NAME: Emma Guthrie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dotes of service): --	16. SOCIAL SECURITY NO.: 237-30-4529 17. INFORMANT: The Medical Records Address: The Clinical Center, Bethesda, Maryland 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Sepsis and pneumonia with partial atelectasis — INTERVAL BETWEEN ONSET AND DEATH: days

5810

DUE TO (b): Bilateral pleural effusion with massive ascites — weeks to months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Focal necrosis and fatty metamorphosis of the liver — months to years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (X) (this hospital) attended the deceased from 22 May, 19 67, to 11 June, 19 67, that (X) (we) last saw the deceased alive on 11 June 19 67, and that death occurred at 9:30 M, from causes and on the date stated above.

22a. SIGNATURE: David F Paulson M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ P

22b. DATE SIGNED: 12 June 1967

22c. PHYSICIAN'S NAME (Type): David F. Paulson, MD

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/16/67	Lovein Cemetery	Nashville, Ga.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Home Inc. Nalley's Funeral	Mt. Rainier, Maryland	JUN 16 1967	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08512

CERTIFICATE OF DEATH

08506

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Damascus
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): 9069 Main St.

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Damascus
d. STREET ADDRESS: 9069 Main St.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: Elizabeth — Lost: Whiteman
4. DATE OF DEATH: Month: June — Doy: 26 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: May 29, 1882
9. AGE (In yeors lost birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): Belle Plain, Kan.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Cornwell
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No
16. SOCIAL SECURITY NO.: 217-32-0068
17. INFORMANT — Address: Richard C. Whiteman, Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 HOURS
DUE TO (b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 10 YEARS.
DUE TO (c):
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor — Hour o.m. p.m. — 19
20d. INJURY OCCURRED While ot work [ ] Not While ot work [ ]
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/15, 1967, to 6/26, 1967, thot (I) (this) lost saw the deceased alive on 6/24 1967, and thot death occurred at 4A M, from couses ond on the dote stated above.

22a. SIGNATURE: James P. Kerr — M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [X] STAFF PHYS. [ ]
22b. DATE SIGNED: 6/28/67
22c. PHYSICIAN'S NAME (Type): James P. Kerr, M.D.
22d. ADDRESS: Damascus, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 29, 1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
23d. LOCATION (City or Town) (County) (State): Frederick, Md.

24. FUNERAL DIRECTOR: Olin L. Molesworth, ADDRESS: Damascus, Md.
25a. RECD BY REGISTRAR DATE: JUN 30 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08513 08507

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Springs
   c. LENGTH OF STAY IN 1b: 3 mo.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Holy Cross

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Springs
   d. STREET ADDRESS: 1940 Kimberly Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Augusta — Middle: Helen — Last: Wickham

4. **DATE OF DEATH**: Month: June — Day: 24 — Year: 1967

5. SEX: Fe

6. COLOR OR RACE: Wh.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/20/16

9. AGE (In years last birthday): 50 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Wushnak

14. MOTHER'S MAIDEN NAME: Minnie Lasanska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO.: 577-10-0610

17. **INFORMANT**: Guy F. Wickham — Address: 1940 Kimberly Road Silver Spring, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last. DUE TO
(c)
1538

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Manth, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Hame, farm, factory, street, affice bldg., etc.)

20f. (City or tawn) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from June, 1966, to 6/24, 1967, that (I) ~~(we)~~ last saw the deceased alive an 6/23 1967, and that death accurred at 9:30 A M, from causes and an the date stated abave.

22a. SIGNATURE: Blaine H. Eig, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/24/67

22c. PHYSICIAN'S NAME (Type): Blaine H. Eig

22d. ADDRESS: 8641 Colesville Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 27, 1967

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d. LOCATION (City or Town) (County) (State): Prince Georges Co., Maryland

24. FUNERAL DIRECTOR: Glen Carter — Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue Silver Spring, Md.

25a. REC'D BY REGISTRAR — DATE: JUN 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

4 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medicol Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08514 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 08508

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SAN & HOSP

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK — 15.1
d. STREET ADDRESS: 6615 WESTMORELAND AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

99

3. NAME OF DECEASED (Type or print): First WALTER — Middle BLAINE — Last WILLIAMS SR.
4. DATE OF DEATH: Month 6 — Day 18 — Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-18-01
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): TENN.
12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: SAM. H. WILLIAMS
14. MOTHER'S MAIDEN NAME: ELLA BAILEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 409-28-0884A
17. INFORMANT: 5014 TAKOMA Address AVE T.P. — CLEARENCE WILLIAMS - SON

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency
DUE TO (b): Coronary Artery Heart Disease.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

3

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒; and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Stapp M.D.
EXAMINER'S NAME (Type): BELDEN R. STAPP M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, County, county): Wheaton
22. DATE SIGNED: 6/19/67

2

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: June 21-1967
23c. NAME OF CEMETERY OR CREMATORY: Jona Cemetery
23d. LOCATION (City or Town) (County) (State): Laytonsville Montgomery Md

24. FUNERAL DIRECTOR: Arthur Walters — ADDRESS: 254 Carroll St. N.W. Washington, D.C. 20012
25a. REC'D BY REGISTRAR DATE: JUN 21 1967
25b. REGISTRAR'S SIGNATURE: [signature]

Items 18&21 Film 390 7-3-67

1 8

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08515

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08509

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b 10 ~~8~~ yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) 10820 Georgia Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15-1
d. STREET ADDRESS 10820 Georgia Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Claude Middle Abraham Lost Wood
4. DATE OF DEATH Month June Day 3 Year 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 28, 1901
9. AGE (In years last birthday) 65 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor-
10b. KIND OF BUSINESS OR INDUSTRY Real Estate
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Samuel Abraham Wood
14. MOTHER'S MAIDEN NAME Eva Twyman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None
16. SOCIAL SECURITY NO. 710-18-4816
17. INFORMANT Address WIFE Mrs. E. Wood, 10820 Georgia Ave. S.S.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4221
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒; and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Keap M.D.
EXAMINER'S NAME (Type) BELDEN R. KEAP, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, City, Town or county) Gaithersburg
22. DATE SIGNED June 4, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF June 7, 1967
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery
23d. LOCATION (City or Town) (County) (State) Prince Georges Co., Md.

24. FUNERAL DIRECTOR Glen Carter Allen Carter ADDRESS 8434 Georgia Avenue Silver Spring, Md.
Warner E. Pumphrey, Inc.
25a. REC'D BY REGISTRAR DATE JUN 8 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08516

CERTIFICATE OF DEATH

08510

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: 206 Russell Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Yankey, Middle: Loy Allen, Last: Yankey

4. DATE OF DEATH: Month: 6, Day: 14, Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/8/04

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miller

10b. KIND OF BUSINESS OR INDUSTRY: Mill

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Yankey

14. MOTHER'S MAIDEN NAME: Victoria Halterman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Hospital Records , Address: Olney, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Carcinoma of Prostate — 2 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-27, 1967, to 6-14, 1967 that (I) (we) last saw the deceased alive on 6-13 19 67, and that death occurred at 5:40 P M, from causes and on the date stated above.

22a. SIGNATURE: Baltazar E. Perez — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-14-67

22c. PHYSICIAN'S NAME (Type): Baltazar E. Perez

22d. ADDRESS: 10305 Folk St., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 17 1967

23c. NAME OF CEMETERY OR CREMATORY: Flower Hill

23d. LOCATION (City or Town) (County) (State): Derwood Montgomery Md.

24. FUNERAL DIRECTOR: Francis H. Barber — ADDRESS: Laytonsville Md.

25a. REC'D BY REGISTRAR: DATE JUN 16 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

Items 18&21 Film 390
7-18-67 ams

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08517

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08511

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 6903 Tilden Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALLEN Middle Soong Last YAPLEE
4. DATE OF DEATH: Month June Day 4 Year 1967

5. SEX: MALE
6. COLOR OR RACE: Oriental
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-14-1924
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Research Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Private Industry
11. BIRTHPLACE (State or foreign country): WASHINGTON
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Soong YAPLEE
14. MOTHER'S MAIDEN NAME: Fung Ying

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
16. SOCIAL SECURITY NO. (If yes give war or dates of service):
17. INFORMANT: 6105 West 18nd St Hyattsville Md. (Address) Brother - Benjamin Yaplee

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis acute — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.
570.4
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Intestinal obstruction — 48 hrs.
DUE TO
(c): Fecal impaction — days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Sedation with high doses of Thorazine
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John G Bell M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)
22. DATE SIGNED: 6/14/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 6-12-1967
23c. NAME OF CEMETERY OR CREMATORY: Baltimore Nat'l. Cem.
23d. LOCATION (City or Town) (County) (State): Baltimore, Md.
24. FUNERAL DIRECTOR: Joseph Gawler's Sons, Inc. N.W.
ADDRESS: 5130 Wisc. Ave. Wash. DC
25a. RECEIVED BY REGISTRAR DATE: JUN 12 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67